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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Rowe: in Ch.

Hearing held in Court Room 20
Court House
361 University Avenue
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamek, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

July 14th, 1983

VOLUME 12

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1 ROYAL COMMISSION OF INQUIRY INTO CERTAIN
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3 AND RELATED MATTERS.

4 Hearing held in Court Room 20,
5 Court House, 361 University
6 Avenue, Toronto, Ontario, on
7 Thursday the 14th day of July,
8 1983.

9 THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
10 THOMAS MILLAR - Administrator
11 MURRAY R. ELLIOT - Registrar

12 - - - - -
13
14 APPEARANCES:

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16 D. HUNT)	Counsel for the Attorney-
17 L. CECCHETTO)	General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
18 I.G. SCOTT, Q.C.)	Counsel for The Hospital for
19 I.J. ROLAND)	Sick Children
20 R. DEVINS)	
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23 B. SYMES	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

24
25 (Cont'd)



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(b)

1	<u>APPEARANCES:</u> (Continued)	
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4	G.R. STRAHTY)	Counsel for Phyllis Trayner - R.N.A.
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6	J.A. OLAH	Counsel for Janet Brownless (Vereecken) - R.N.A.
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8	F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
9	W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child Jordan Hines)
10	J. SHINEHOFT	Acting for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)
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---Upon commencing at 10:00 a.m.

THE COMMISSIONER: Yes, Mr. Lamek.

MR. LAMEK: Thank you,

Mr. Commissioner. Dr. Rowe, please.

DR. RICHARD DESMOND ROWE, Resumed

DIRECT EXAMINATION BY MR. LAMEK: (Continued)

Q. Dr. Rowe, before we go any further in your evidence there is something that I understand you want to clarify or correct from yesterday's evidence and I think it is proper that you do that. Towards the end of the day yesterday, and Mr. Commissioner, this is at page 1935 of yesterday's transcript, and speaking about the Velasquez child, I put this question to you, Doctor:

"I don't know, Doctor, if, since

August 25th, 1980 you have been asked this question but I have to ask you: were the terminal events recorded in the chart of this child consistent with digoxin intoxication?

A. Yes.

Q. That is to say, a measure of arrhythmia, slowing of the heart seizure-like activity?

A. Yes."

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Now, I understand through your counsel,
Dr. Rowe, that there is something you want to say
about that and I think it proper that you say it now
and correct any misimpression that you may have
given yesterday with that answer.

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A. Well, yes, the answer "yes"
is that that series of events could occur with
digoxin but it is most likely due to, or at least
is possibly due to other factors as well.

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Q. I am sorry, I want . . . to be
fair, I am looking at the whole course of events
which as you recall, and we can check the chart if
necessary, was an administration of a dose of
naloxone.

A. Yes.

Q. That was larger than recommended,
but nevertheless a dose of naloxone.

A. Yes.

Q. Given to a child who appeared
to be suffering from, not suffering, affected by the
codeine that he had received.

A. Yes.

Q. And a response by the child
to the naxolone, but by the doctor
considered not yet a sufficient response and then



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an administration of a further dose of naloxone,
following which the child displayed certain symptoms
and almost immediately arrested.

3

A. Yes.

4

Q. Now, is that sequence of
events consistent with digoxin intoxication is
essentially my question?

5

A. Well, it is possible that it is,
but it is also possible that there might be, it might
be related to the drug itself.

6

Q. Yes, of course. Okay. I'm
sorry, then I hadn't really misunderstood your answer
yesterday?

7

A. No.

8

Q. I understood you were now
attaching some significance to the response to the
initial dose of naloxone.

9

A. The reason I say that is
because the response to naloxone caused the heart
rate to improve and one might not expect that if it
was digoxin intoxication.

10

Q. You cannot tell me that it
would not happen?

11

A. No, I could not say it would
not happen.

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3 THE COMMISSIONER: Did you say the
4 naloxone, whatever other name you used was
5 administered, did you say it improved the heart rate?

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7 THE WITNESS: It improved the heart
8 rate and that would be less likely to occur if there
9 were digoxin as a basis for the slowing and so on.

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MR. LAMEK: Q. Dr. Rowe, I hope
I am being fair about this, and I don't want to take
that answer any further than it is capable of
going. Do I understand you now to be saying, and
please tell me if I am misstating this, do I under-
stand you now to be saying that the sequence of
events and the symptoms and responses of baby
Velasquez in the last few minutes of his life may be
consistent with digoxin intoxication, but you would
rather doubt it in light of the response in increased
heart rate to the first dose?

A. Yes.

Q. Thank you.

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THE COMMISSIONER: I'm sorry, I
don't quite understand that because the naloxone is
designed to improve the heart rate is it not, isn't
that the purpose of it, or is its purpose to counter-
act the codeine.

THE WITNESS: The purpose is to



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counteract the effects of the codeine.

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MR. LAMEK: Q. Perhaps I could ask this question, Mr. Commissioner, I think the same thing is bothering me. If the slowed heart rate were, as was believed, the result of a response to codeine, and I take it one could assume that codeine has an affect, either directly on the heart or via the central nervous system upon heart rate?

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A. Yes.

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Q. And therefore naloxone in counteracting those effects I take it must similarly be taken to have an effect either directly on the cardiovascular system, which is thought not to be the case, or upon the central nervous system that is indirectly affecting the heart rate.

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A. Yes.

11

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Q. And if therefore naloxone is capable indirectly of affecting the heart rate, is that the reason that you cannot categorically say these events are inconsistent with digoxin intoxication?

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A. I am not sure of the full answer to that. I think you would have to ask a pharmacologist, our pharmacology friends to do that.

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Q. Okay.

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A. But that was my clinical
impression on surveying the data.

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Q. The question has been raised
in your mind and it is proper you voice it for us,
Doctor, and we will take that up with the pharmacolo-
gists.

5

6

We have one more of the cases to
consider that were reviewed at the September 26th
meeting, and that was the case of Kelly Ann Monteith,
and there is behind you on the easel a diagram,
Dr. Rowe, a diagram that purports to be the heart
of Kelly Ann Monteith. Are you able to tell me
whether from your review of the chart the diagram
accurately depicts the state of that child's heart?

7

A. Yes, it does.

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MR. LAMEK: May that, Mr. Commissioner,
be the next exhibit.

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THE COMMISSIONER: 63.

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---EXHIBIT NO. 63: Diagram of Heart of Kelly
Ann Monteith.

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MR. LAMEK: Q. Now, Doctor, we
are treading the now reasonably well worn path, but
could you describe for us first please the anatomy
of that heart and the defects and deformities which
existed in it and tell us something of the clinical



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significance of those defects?

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A. Yes. The primary problem in this child's heart is not in the structural arrangement of the pump, but in the fact that there is an abnormal position for the origin of the left main coronary artery. We haven't diagramed it on the normal, but both the right coronary artery and the left coronary artery in the normal individual arise just above the aortic valve in the aorta on the left side of the arterial trunk. Those arteries pass on the left side mainly to the left heart and on the right side mainly to the right heart. There is some communication between the two sides. But the blood supply to the heart muscle which is resulting from the normal supply is distributed under systemic pressure, that is under the pressure in the aorta and passes through the entire muscular portion of the pump. That supply is necessary to maintain an integrity of the function of the heart and its electrical activity.

The condition which Kelly Ann Monteith had was one in which the right coronary artery arises in the usual fashion from the aorta as is shown here. So this is a diagram demonstrating a normal distribution of the right coronary artery to

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2 the right side of the heart. The left coronary,
3 however, which predominantly supplies the muscle
4 of the left ventrical or main pumping chamber,
5 arises not from the aorta at all but is arising from
6 the back end of the pulmonary artery just above its
7 valve. What that produces is no difficulty during
8 life in the womb to any great extent. It may
9 produce difficulties in the latter part of the
10 pregnancy but probably not gross disturbance of
11 function. Because during that time the heart acts
12 like a single pump because of that matter of the
13 ductus arteriosis that I mentioned before and
because the lungs are not expanding.

14 Immediately after birth when the
15 pressure in the pulmonary artery starts to fall
16 after the ductus begins to constrict, and therefore
17 this side of the heart becomes a low pressure
18 slurping type pump, then the perfusion of this artery
19 from the pulmonary artery stops, because it is not
20 enough to send the blood all the way through a
21 chamber with which it is contracting systemic
pressure.

22 So what then develops is a serious
23 problem of ischemia, or lack of oxygen supplied to
24 the muscle of the left ventrical, and the degree to
25



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2 which that happens depends on a number of individual
3 features in any individual with this condition.

4 The right coronary artery enlarges
5 enormously because it is the only artery that can
6 take blood into the system, and small branches, which
7 are collateral vessels between the coronary systems,
8 they are very small branches, that unite the two
9 systems at the periphery of the arteries will
10 communicate with this branch here, so that blood
11 then goes from this artery supplies the muscle on
12 the right side and then branches will carry through
13 over to this side. Blood will then go off up here
14 and be siphoned as it were into the pulmonary artery.
15 That means that there is continuing progressive
16 damage but that it may be modified by how much blood
17 can enter the system from the other side.

18 Obviously if none could get across
19 then within a week or two the baby would die. But
20 when some can get across as it often does, although
21 it may be a relatively small amount, then some of
22 that on its way up here will nourish the muscle of
23 the left heart.

24 The disturbance therefore that
25 happens on the whole and in the majority of these
patients it occurs early, is that they develop



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Rowe, dr.ex.
(Lamek)

1958

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2 breathing difficulty because of left heart failure,
3 that is this whole ventrical or pump becomes subjected
4 to ischemic damage which is more or less the same as myo-
5 cardial infarction in an adult. It is just as if you
6 had plugged this coronary artery with a clot. But
7 it is modified so that it is a gradual and repetitive
8 process and small bits of muscle die all the time.
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But eventually the chamber becomes mostly dead muscle and then all that is left is a very thin amount of muscle which cannot possibly cope with the work that the left pumping chamber is supposed to do.

In addition, the muscular apparatus that supports the mitral valve becomes damaged by this ischemic process and mitral regurgitation, meaning leakage back with each squeeze of the pump into the receiving chamber of the left atrium becomes important and that in itself can produce massive enlargement of the left atrium, as it did with this baby.

In fact, the principal presenting symptoms to the family doctor in this situation were that this baby appeared to have obstructed breathing and that was because the whole of the top left chamber, the left atrium was so enlarged that it was compressing the left main stem bronchus, that is, the main respiratory passage or tube to the left lung.

The treatment of this condition is initially that of treatment of the heart failure, but the fundamental intervention would have to be surgery.

The theoretical approach would be to transplant or transpose, not transplant, transpose



BB.2

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2 the anomalously placed coronary artery from the
3 pulmonary artery back to where it should be in the
4 aorta. The difficulty in doing that is the fact
5 that the diagnosis is seldom realized until the
6 baby has had substantial death of heart muscle, so
7 that the risk of doing such an operation, especially
8 in a very small baby, is extremely high.

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Other approaches have been suggested
which simply mean tying off this artery, and that
was the original operation available in which the
artery is tied off here, and that means that blood
can't syphon back into the pulmonary artery and,
therefore, there is more opportunity for it to
profuse or supply and nourish the muscle. But again,
that is dependent upon how much of these collateral
bypasses are in effect, and particularly since there
is a tendency for those to close down for some time
after birth before being opened up again.

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So, the mortality with this condition
is high and the survivors are those of whom there is a
surviving amount of muscle for one reason or another,
usually related to the collateral supply. In the
ordinary course of events, with relatively modest
collateral flow, these babies do very poorly indeed
and usually succumb, and the difficulty is that even



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2 if you can get them to operation, most of them will
3 die during the procedure.

4 It is a very disturbing and
5 problematical issue.

6 Q. Doctor, thank you. The
7 minutes of the meeting of September 26 contain a
8 rather terse summary of the condition of Baby
9 Monteith, and you have expanded upon that considerably
10 for us. Indeed, the manuscript notes of that meeting
11 really don't add very much to what was said about
12 Baby Monteith on the 26th of September.

13 But it does appear, does it not,
14 that the baby did go for cardiac catheterization and
15 some 16 hours after that, according to the manuscript
16 notes, I assume this was discussed at the meeting,
17 the heart went into ventricular fibrillation and the
18 baby died?

19 A. Yes.

20 Q. And Baby Monteith died in the
21 early morning of August the 19th, 1980, I believe?

22 A. Yes.

23 Q. Now, she had been scheduled
24 to have an operation on August the 21st, hadn't she?

25 A. I believe that is so.

Q. Yes. And that I think is



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2 referred to in the reporting letter on page 12 of
3 the chart. 12 is not easily legible because it is
4 printed right over the words on the page "Chart Copy".
5 There is a letter dated August 18, 1980 written by
6 Michael Shaffer, Cardiology Fellow for Dr. Olley
7 to Dr. Verbeek, who I take it was the referring
physician?

8

A. Yes.

9

Q. And in the penultimate
10 paragraph of the letter, Dr. Shaffer reports that:

11

"Kelly Ann Monteith was discussed
12 at our cardiovascular surgery
conference and with the above findings
13 it was felt that she would benefit
14 from an attempt to repair the
15 anomalous origin of the coronary
16 artery and she is presently scheduled
17 for corrective surgery on the 21st of
18 August, 1980."

19

I take it that it was proposed that
20 an operation of the kind you described, to relocate
21 the origin of the coronary artery, was proposed?

22

A. Yes.

23

Q. And that decision, as I understand it, was made at the surgical conference that

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2 was held on August the 18th, that is to say, the
3 date of Dr. Shaffer letter, the day before the
4 baby died?

5 A. And that was following the
6 cardiac catheterization that morning.

7 Q. Following catheterization,
8 that's right. Catheterization in the morning,
9 surgical conference that same day and the decision
10 to schedule her for surgery on the 21st and Shaffer
11 wrote reporting the status of the matter to the
12 referring physician?

13 A. Yes.

14 Q. And you have told us that the
15 surgery that was proposed for the Monteith baby had
16 to be considered high-risk surgery?

17 A. Yes.

18 Q. Because of the nature of her
19 particular ailment?

20 A. Yes.

21 Q. And the damage that she may
22 already have sustained as a result of that
23 deformation?

24 A. Yes.

25 Q. Had any thought been given to
scheduling her for surgery before August 21st?



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A. I expect that is so. I don't know for sure, one would have to ask those who are responsible at the time because I can't see any evidence of that here. I would think, judging from the usual procedure, that this youngster would be regarded as an urgent case, that they probably would not want to do it the same day as the cardiac catheterization but they would be trying to fit the baby into the schedule on an emergency basis.

Q. Yes. And would you normally consider an emergency basis something less than three days hence?

A. Well, it would depend upon the situation at the time. If the surgeons can fit it in they would. If they thought stabilization was worth pursuing, they might say no. They would have to make a number of judgments on that and I think you would have to ask them as to what the reasons might have been in this particular instance.

Q. Well, I recognize there may well have been scheduling problems, OR time and surgeons' time, although, I take it that of necessity there is some flexibility in their system to take care of a truly emergency situation?

A. Oh, yes.



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Q. But the scheduling of surgery for the 21st of August, that scheduling having occurred on the 18th, does suggest, does it not, that it was at least contemplated that this baby would survive until the 21st?

A. I don't think that we could make that assumption in a baby with this condition. I think that this sort of baby is liable with ischemic damage to continuing infarction at any time and I think that we couldn't assume that everything will be all right for several days; from the medical standpoint I'm talking about.

Q. Yes. Is it of significance that the baby was two months old at that time and that with this structural defect in the heart, this anatomical defect, she had nonetheless survived for two months. Did that suggest that in fact in one way or another there was some reasonable ~~er~~ profusion of the right side of the heart to have been able to have survived that long?

A. I'm not sure that I would agree with the term "reasonable" because the baby had been in difficulty for some time.

Q. Yes.

A. But there was enough to allow the baby to survive, to be sure.



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2 Q. Well, once again, we have
3 got language by Dr. Freedom, that I suppose he himself
4 will have to answer for - not answer for but to
5 explain - but on page 13 of the chart there is
6 Dr. Freedom's reporting letter to Dr. Verbeek, dated
7 August 19th. This was the day following the night
8 in which Kelly Monteith died, and in his second
paragraph he says:

9 "As I mentioned to you, she was
10 discussed at our Surgical Conference
11 on August 18th, and it was felt that
12 she would be a candidate for some
13 type of surgical procedure to
14 re-direct her coronary artery to her
15 aorta. Certainly with a severe and
16 global impairment of her left
17 ventricular function, she was
18 considered a high risk, and as you
19 know by this time she died suddenly
20 early in the morning of August 19th."

21 Now, maybe suddenly is not so
22 difficult a word to describe as unexpectedly?

23 A. Yes.

24 Q. But I take it we'll agree that
25 the death of this baby was sudden when it occurred?



BB.9

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A. Yes.

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Q. And am I right in my reading
3 of the chart, Doctor, that findings at autopsy
4 revealed a more serious condition than had been
5 suspected?

6

A. The findings at autopsy
7 revealed more extensive myocardial destruction than
8 had been anticipated, although, I don't think anybody
9 was under the impression that there was only a little
10 bit of myocardial destruction.

11

Q. And as Dr. Freedom reports
12 in his letter of August 19th, really, the chances of
13 her surviving surgery have been very slight indeed
14 in light of what was discovered on autopsy. Is that
fair?

15

A. I would probably go further
16 and say there was probably no chance.

17

Q. But that of course wasn't
18 known in its full detail and to its full extent as
19 at the time of scheduling the child for surgery?

20

A. No.

21

Q. And for one reason or another
surgery was scheduled for the 21st and the baby
22 didn't make it into the operating room?

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A. Correct.

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Q. Now, may I refer you again to the report of Dr. Bain, and I will put this before you, Doctor, if you look at page 6 of that report. I'm sorry, do you have the report with you today?

A. No, I don't have it with me, I'm sorry.

Q. At page 6 of the report, referring to Kelly Ann Monteith, Dr. Bain refers to her deformation and says:

"She was placed in this category ... " that is this category for comment by him:

" ... because there was some feeling prior to the post mortem that perhaps she should not have died when she did. At post mortem she had very severe heart disease and was really not compatible with life.",

he says.

But I am directing my attention, Doctor, to the state of knowledge of the surgeons and the cardiologists while this baby was still alive.

Was it your understanding, as Dr. Bain seems to record, that there was some feeling prior to post mortem that Kelly Ann Monteith perhaps



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2 should not have died when she did. Was there a
3 measure of surprise that she died just when she did?

4 A. I think a number of people
5 may have suggested that. I can't recall exactly, but
6 I would imagine, because she was talked about in our
7 conference.

8 Q. Yes.

9 A. That there had been some
10 concern on the part of nurses that perhaps she should
11 not have died. I think the problem that enters into
12 that aspect is the ability of not the question of
13 deciding the diagnosis, but the ability of being able
14 to assess the extent of the myocardial infarction.

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2 Q. The baby was originally admitted
3 to Ward 4A on August 14th, as I understand it?

4 A. Yes.

5 Q. And was transferred the same day
6 to the ICU?

7 A. Yes.

8 Q. And that appears at page 38 of
9 the chart in the progress notes.

10 The first note records that at 7:45 p.m.,
11 the baby having been admitted to 4A was ordered
12 transferred to the ICU. And I take it that reflects
13 a measure of concern about the baby at that stage and
14 the baby being in some measure of difficulty?

15 A. And I think - that is true, but
16 as well there is a background here of there having been
17 thought to be a condition known as a vascular ring.

18 Q. A vascular?

19 A. Ring, r-i-n-g.

20 Q. What is that?

21 A. Congenital condition in which the
22 aorta, instead of being a single vessel going up and
23 around and down, splits into two portions and
24 surrounds the trachea or major windpipe.

25 Q. Yes.

A. And so compresses it. And the



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2 symptoms in this baby had been of such a nature in
3 terms of difficulty breathing and noisy breathing
4 that the family physician was concerned that that
5 might be the diagnosis.

5

6 For that reason I think everybody was
7 primed to the possibility that this baby might need
8 intubation, and I think as I read that - I can't be
9 sure - but I would think that that might have had
some influence on the decision to transfer.

10

Q. Yes?

11

A. And I believe at some stage
Dr. Freedom did mention that to me.

12

13

Q. All right. It appears from page
41 of the chart Doctor, again, in the progress notes,
that having spent the night in the ICU the baby went
back to the ward on August 15th?

16

A. Yes.

17

18

Q. And appeared then to be in a more
stable condition?

19

A. Yes. I think that is what the
notes say.

20

21

Q. Yes. The nursing notes certainly
on the 15th and 16th suggest, do they not, that the
baby is now more stable?

23

A. Yes.

24

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Q. It was on digoxin and lasix. On page 41 the note of 15/8/80, a third of the way down the page:

"Returned from ICU at 1400 hours.

Vital signs stable. Babe's irritability much less problem.

Heart rate down, blood pressure stable, colour good, chest no wheezing now."

A. Yes.

Q. And the stay in the ICU appears to have been beneficial to the child?

A. Yes.

Q. And essentially the same pattern occurs in the nursing note, does it not, through the 17th and 18th of August?

A. Yes.

Q. The continuing report appears to be of stability at the present time?

A. Yes.

Q. Page 47 of the chart there is a note as to the terminal events and the resuscitation attempt.

At 3:40 in the morning on the 19th there



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was a Code 25 to this baby. Brief history at the beginning of the thing.

3

A. Yes.

4

Q. And apex - is that irregular?

5

I can't read it very clearly. I am afraid it's not a very good copy.

6

A. I can't read it either.

7

Q. All right. In light of what comes later it may not be a bad guess because it says a little later the monitor showed ventricular fibrillation?

8

A. Yes.

9

Q. What is recorded by way of symptom and event, as I read this, and I would be grateful for your help, Doctor, is some observation as to the apex pulse, pupils dilated - do I read that correctly, immediately below that line?

10

A. Yes.

11

Q. Ventricular fibrillation?

12

A. Yes.

13

Q. To which the child reverted after there had been some attempt to resolve that.

14

And then sinus bradycardia.

15

If I look at page 49 of the chart as well I believe there is another symptom there. At

16

17



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2 3:30 in the morning, immediately before this Code 25,
3 Nurse Nelles reports or records:

4 "Babe again vomitted approximately 15
5 cc's of bile fluid ... child appeared
6 to stiffen and eyes began to roll in
7 her head ... seizure like activity."

8 Is that right, Doctor?

9 A. Yes.

10 Q. And then we have got ventricular
11 fibrillation, irregular heart rate, bradycardia and
12 a failure to resuscitate?

13 A. Yes.

14 Q. And fairly, once again, I think
15 one can say those terminal events took a rapid course?

16 A. Yes.

17 Q. Now I know I have asked you this
18 in connection with another chart, Doctor, but if you
19 will look at page 48 of the chart following the arrest
20 note and the resuscitation note, do you attach any
21 significance to the fact that the nursing note for the
22 period 7:00 p.m. to 3:00 a.m. August 17 to 18 appears
23 not to have been completed until after the death of
24 the child?

25 A. Yes.

Q. I am sorry, you do attach some



1

2 significance to that?

3 A. No, I don't. I notice that it
4 has been completed after the death.

5 Q. Does that suggest to you that
6 there was anything of any particular significance in
7 that period which called for immediate charting as it
8 was happening?

9 A. I don't think that when things
10 happen at that speed anybody has time to chart that,
11 but I believe that the nurses generally tend to write
12 on pieces of notepaper and then --

13 Q. And do all the charting together?

14 A. I am not absolutely sure. You
15 would have to ask --

16 Q. We had better ask someone who
17 does it?

18 A. Right.

19 Q. Okay.

20 A. But I wouldn't attach any
21 significance myself to that.

22 Q. It is fair, is it, that not only
23 was the course of these events rapid but they appear
24 to have had a sudden onset?

25 A. Yes.

Q. And there appears to have been



1

2 no prior warning that this child was at such imminent
3 risk of death?

4 A. In terms of --

5 Q. Of the observable signs and
6 behaviour of the child. The child had apparently been
stable?

7 A. Yes.

8 Q. For two or three days and then
9 suddenly went into this pattern of terminal events?

10 A. Yes.

11 Q. Which is essentially I think what
12 Dr. Olley said in his categorization report on page 50
13 the chart, isn't it? In very much shorter form the
14 final sentence under "Procedure":

15 "Sixteen hours after the procedure the
16 child suddenly developed ventricular
17 fibrillation and could not be
18 resuscitated."

19 A. Yes.

20 Q. There is no real question about
21 the suddenness and the rapidity of those events.

22 A. Hm-mm.

23 Q. Do you, Doctor, in considering
24 this death, consider the onset, the nature and rapid
25 course of the terminal events to be of any significance?



C 8

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A. Oh, they were significant because
they implied the baby was dying.

4

Q. Yes, obviously, but did you
attach any significance to them in considering why or
what caused this baby to die?

6

A. No.

7

Q. Were you satisfied that the baby's
death and the time and manner of her death were
completely consistent with her physical condition?

10

A. Yes, I was.

11

Q. And once again as you told me
forthrightly yesterday, I take it you can say no more
than that her death and the time and manner of her
death were consistent with her condition, with the
condition of her heart and her anatomical deformation?

15

A. I might be able to say that that
would be the usual manner of death of this particular
group of babies.

18

Q. Once again may I ask you is that
roster of symptoms and their pattern of onset and
sequence equally consistent with digoxin intoxication?

21

A. Yes.

22

Q. Now, Dr. Rowe, by the end of
September then two meetings had been held and six of
the ward deaths that had occurred in July and August

24

25



1

2 had been reviewed.

3 How would you sum up the results of
4 those two meetings? May I ask you a particular thing
5 first? You have told me one of the purposes of the
6 meeting and I take it an important purpose was to
7 reassure the nurses that it wasn't their mismanagement
8 of cases that was the cause of these deaths.

9 Did the meetings appear to succeed in
conveying that message?

10 A. Well I hoped they did. I don't
11 know whether they did because I didn't pre-test or
12 pro-test their responses.

13 Q. There was none of that nasty word
feedback later?

14 A. That is right.

15 Q. All right. No regurgitation?
16 In the cardiac sense not in the other.

17 A. No.

18 Q. Other than that what did you
19 perceive the results of the meetings to have been?

20 A. Well, I think that we all
21 gathered the impression that this had been a useful
22 forum as we proceeded and that there would be - there
23 were a number of mutual aspects with both nursing and
24 physicians that might properly be used to try and look

25



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2 C 10 at the problems we had to deal with in facing these
3 seriously ill babies.

4 We did obviously have concerns about
5 whether, when babies are very seriously ill, there
6 should not be some way of having more detailed
7 monitoring or more one-on-one type nursing than might
8 be possible on the ward in its ordinary form.

9 So the question was raised at the end of
10 the conference about the matter of having something in
11 the way of an intensive care area, recognizing that you
12 cannot have an intensive care unit on the floor because
13 it is a very highly specialized area requiring
14 different type of personnel, but believing that there
15 might be some benefit to having an intermediate
16 intensive care unit.

17 Again that is a word that could be
18 defined in a number of different ways, but it is what
19 I regard as intermediate between ward care of the
20 ordinary regular type which was being provided and
21 truly intensive care.

22 It seemed to me at that time and I think
23 that the reaction that I received led me to believe
24 that it would be worthwhile looking to that question,
25 and it was suggested as the minutes record that we sit
down and try and come to work out the needs that are



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2 necessary, that the nurses might feel necessary and
3 the physicians might feel necessary to have that and
4 to work out ways in which that might be accomplished.
5 That was I think a major conclusion.

6

Q. Yes?

7 A. The other conclusions, and there
8 may have been more discussed than are revealed there -
9 I haven't obviously covered them all; the head nurses
10 seemed to have more detailed information than I have -
11 but I believe one of the things we said was that there
12 should be a way in which the dosage schedule of drugs
13 which are used in cardiac arrests should be made a
14 little more obvious than just the handbook, and so
15 the decision was made that the senior cardiac fellow,
16 Dr. Jedeikin, and the nursing staff would work on that
17 issue and work out something that was suitable from
18 both points of view.

19

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3 We also thought that these seemed to
4 have been productive in terms of patient care manage-
5 ment. And so that there would be an advantage to
6 continuing with such discussions from time to time.
7 I believe there were some discussions about what
8 was the best time for nursing, and apropos their
9 problem of time and what might be suitable for
10 the physicians. It wasn't decided at that meeting
11 exactly what would be done, but it was decided that
12 there would be another meeting and it would probably
13 be held on the Monday, in one or other places of the
14 Hospital depending upon what was resolved later.

15 Q. I am sorry, Doctor, have you
16 finished?

17 A. I have finished.

18 Q. I think in light of what we
19 know about what came later, would it be fair to say
20 that the - perhaps the most significant of the
21 conclusions that came out of this was the consensus
22 that developed as to the desirability of something
23 called an intermediate Intensive Care Unit?

24 A. Yes.

25 Q. Is that right?

A. Yes.

Q. You said you regarded it as



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2 something half way between normal ward care and the
3 kind of care that is provided in an Intensive Care
4 Unit. Unfortunately, Doctor, we laymen all have a
5 rather different idea of what an Intensive Care Unit
6 is. Can you help us just a little, what did you have
7 in mind as constituting an intermediate Intensive
Care Unit?

8 A. Well, we hadn't formulated
9 exactly at that stage what it should be. I think
10 perhaps at the beginning I was wondering if it might
11 be possible to have some respiratory assists
12 procedures, though I realized that we couldn't have
13 full ventilation and respirator arrangement.

14 I was more of the opinion at that
15 stage that what we needed was to have a capability of
16 having small babies, who were suffering from very
17 severe heart disease, be able to be monitored very
18 much more closely than was feasible with a pretty
19 stretched nursing staff on the floor. In no way were
20 we making any suggestion that the nursing staff were
21 not doing a superb job, and I think that needs
22 emphasis. The issue was simply that the number of
23 babies seemed to be, the number of sick babies seemed
24 to be higher than we had encountered in the past.
25 The number of younger babies seemed to be higher



D3

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2 than we had encountered in the past. Therefore it
3 seemed that it would be necessary to somehow or
4 other increase the nurse-to-patient ratio to more
5 than was possible under the routine staffing of
6 the ward, even though under special conditions
7 it was possible to adjust that.

8 So that this Intermediate Care Unit
9 really had as its primary objective a means of
10 having more nursing observation upon babies, and that
11 would be possible through an increased number of
12 nurses, because any Intensive Care or Monitoring, or
13 whatever you want to call that unit would by definition
14 demand more nurses per patient.

15 Q. I think I understand the
16 concept now, Doctor, and recognize the desirability
17 of such a unit. Is it fair to say that the existence
18 of an intermediate ICU on or close to hand to the
19 Cardiac Wards in July and August of 1980 might or
20 might not have made a difference with respect to
21 the children whose deaths had been reviewed at the
22 September meetings?

23 A. Could I have that repeated
24 please?

25 Q. Yes. Would the intermediate
ICU have made any difference with respect to these



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children whose deaths were reviewed?

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A. I think in many, probably not,
in terms of outcome. It could conceivably, might
have, changed the time of death, might have allowed
a transfer to the Intensive Care Unit, or other
measures might have been taken somewhat earlier.

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Q. Doctor, haven't we been seeing
a pattern where following a period of relative
stability there has been a sudden onset and a very
rapid course of terminal events?

11
A. That is true.

12
13
14
Q. Are you suggesting that those
children might have already been in an intermediate
ICU had one been available before the onset of those
events?

15
16
17
A. Yes, I think that is probable.
That would be our view with the formation of such a
unit, that the high risk babies would be placed in that
unit so they could be monitored very closely indeed.

18
19
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Q. Doctor, is there any suggestion
in any of the cases that we have reviewed so far that
the problem was that the difficulties of these
children had gone unnoticed? Was it not rather that
events moved so quickly and so inexorably that
intervention was impossible?

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A. Well, that is one explanation.

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It is also possible in a situation where you don't
4 have extremely close monitoring of the type I am
5 talking about, that the events that are taking place
6 that would be noticed under very close monitoring are
7 not recognizable because they are not violent or very
8 obvious things, they are minor things, I think
9 that is experienced in many Intensive
10 Care Units, that you pick up changes in the condition
11 sometime before the baby starts to deteriorate.
12 They are subtle changes but they may be picked up
13 earlier, that's all. I am not saying that in every
14 case we could have achieved prolongation of life,
and that of course is one of the difficulties of
moving rapidly on that suggestion.

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Q. But lacking such a facility,

it is also fair, isn't it, that patients who required
closer observation in the judgment of the physician
in charge, could have that closer observation ordered
for them even on the ward, could they not? A
doctor could order constant nursing care for a
patient if he thought it was required?

A. Or the nurses themselves

might make that decision.

Q. Of if he didn't think constant

nursing care was required he could order shared care,



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2 could he not?

3

A. That is true.

4

Q. And as I understand it
constant nursing care means that that child for whom
that care is ordered has the exclusive attention of
one nurse?

7

A. Yes.

8

Q. A one on one relationship, is
it ont?

10

A. Yes.

11

Q. And shared care, the nurse
is responsible for two, and two only, children,
is that your understanding, Doctor?

14

A. Yes.

15

Q. Now, the patients whose
deaths were reviewed at the two meetings in
September, are you able to tell me whether any above
normal level of nursing care had been ordered for
any of them?

19

A. Well, I can't answer that
question. I am not the responsible physician at
the time and I think only those people can answer
that.

22

Q. But such orders if made by
the doctor will be on the chart, wouldn't they?

24

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A. Not necessarily.

3

4

Q. Let me tell you, Doctor, I am prepared to leave ~~A~~ the evidence at a later stage, and I can give you only what my information is from a review of the charts and the nursing assignments. It is my understanding that the only child for whom any enhanced level of care was ordered was Baby Monteith and for her shared care was ordered.

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Now, if those facts be correct, and

as I say I am prepared to adduce evidence about it, if those facts be correct would it not suggest, Doctor, that the physicians in charge of the management of those children did not perceive their conditions to be such as to require an enhanced level of nursing care?

A. I don't think that follows.

Q. Are you suggesting to me

that if a doctor thought closer observation by either constant nursing care or shared nursing care was necessary for a patient he would not order it?

A. I think he would discuss it with the nursing group, either at resident level, Fellow level or staff level. It would depend upon the capability of that being done I would suspect.

If you want the detail on that, you



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would have to speak to the head nurses and the
physicians are the responsible parties.

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My approach if I was on the ward would
be to speak to the team leader or the head nurse and
say I think this baby needs closer monitoring, if
you can get more nursing that would be fine. If I
thought it should go to ICU I would approach the
ICU staff, but I might not necessarily write that on
the chart.

10

11

12

Q. Doctor, if you were not able
to obtain the level of nursing care that you thought
your patient required, what would you do?

13

14

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A. Well, we would try to get
doubling up of nurses which they try to do, they
try to do this. I think it depends - you have to
realize that there was a shortage of nursing during
that time and there was considerable difficulty in
getting replacements for those that were on vacation,
or were sick, and there was a lot - there were a lot
of times when I understand doubling up of nurses
was the case.

21

22

23

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We also didn't have the same capability
of getting patients into the Intensive Care Unit,
not because the intensivists : wouldn't respond
to discussions on that point but because the Intensive

This has now
become a
fact!



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2 Care area was very highly occupied during that
3 particular period of time. The occupancy had
4 substantially risen in the spring of 1980 and there
5 was always difficulty in getting patients accepted
6 because priorities have to be taken, and the
7 intensivists would certainly not take anyone that
8 we were a little worried about. So there were
9 no answers of that sort that it interfered to
10 some extent with the decision as to what would be
done about a particular patient.

11 Q. Doctor, you have told me that
12 the nurses too are able to make a decision to
13 devote extra or particular care to one or another
14 patient, they don't have to have that ordered for
them in order to make that judgment.

15 You are familiar, are you, Doctor,
16 with something called the NARVEL system?

17 A. Not in great detail, I know
18 about the system. I am not a nursing individual
19 so I don't follow all their detailed procedures,
but I know it is an evaluation procedure.

20 Q. And it is an evaluation
21 procedure is it not to determine the manpower of
22 nursing required to provide care for a given
23 population of patients with particular characteristics.

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A. Yes.

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Q. And it is an assessment that
is made from time to time how many bodies do we need
to do this job for these people.

6

A. It is a system I gather
that is designed to do that.

8

Q. And you are aware I take it,
Doctor, without knowing any of the details of
staffing and scheduling, that nurses from one ward
in the hospital may be assigned to assist and help
out on another ward when there is a particular
demand?

13

A. Well, I am not familiar with
all the details of what the nursing service does,
but I assume it is something like that, but I
don't know for sure.

17

Q. Are you aware whether the
Hospital has a pool of nurses available to come in
by the day as needed, referred to often in assignment
books as per diem nurses, a sort of hospital over-
load system?

21

A. Yes.

22

Q. You are aware of that?

23

A. Yes.

24

Q. You told us of the impression

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3 is what you called it on Tuesday, the impression that
4 you had in July and August of 1980 in which there
5 was a serious shortage of nurses at that time especially
6 at night, do I recall that evidence correctly?

7 A. Yes. I think you have to
8 realize I am getting this feedback from other
9 individuals. Again if you want to know specifics
10 about times when those nurses, when it was perceived
11 by the cardiologists that there was a shortage, or
12 by the head nurses, you would have to ask them
13 directly.

14 Q. But I did ask you on Tuesday,
15 or Wednesday, whether you had any recollection in
16 July and August of any information coming to you
17 from the nursing staff, whether through a nursing
18 specialist or anyone else, that they were short of
19 nurses on the ward. As I recall your evidence you
20 could not recall any such communication?

21 A. No.

22 Q. But your impression, and I
23 think you said your firm impression was that there
24 was a shortage of nurses on the Cardiac Wards at the
25 end of the summer, and particularly at nights I think
you said?

A. Yes.



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Q. And did you think that that
might have had anything to do with the increased
death rate that was experienced on the wards in
those months?

6

7

A. I thought it might have some
relationship.

8

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10

Q. Dr. Rowe, did you make any
effort to confirm the impression you had about the
shortage of nurses at night?

11

A. I didn't examine that directly,
no.

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Rowe, dr.ex.
(Lamek)

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A. I didn't examine that directly, no.

4

Q. Did you ask anybody who might have been closer to the situation than you were whether there was a shortage of nurses at night on your wards?

7

A. I can't recall whether I did. I don't believe I went to the nursing administration or anything of that sort.

10

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Q. Well, Doctor, I suggest to you that if you believed, rightly or wrongly, that there was a shortage of nurses on those cardiac wards at night which may have been contributing to the high on ward mortality rates that were being experienced, then why, by the end of July when five children had died, were you not pounding on the table for more nurses?

A. Well, I think I have told you that I wasn't absolutely sure that this was in relation to the deaths. We just wondered whether there might be the possibility that that could be the case.

Q. Well, with the greatest of respect, Doctor, and I mean no criticism at all, I suggest that you weren't even sure that there was the shortage of nurses about which you had an impression. Is that fair?

Why didn't
he FIND
out?



Rowe, dr.ex.
(Lamek)

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A. We knew there were fewer nurses
on the ward at night than the day. We weren't sure
there was a shortage of nurses, I suppose, if you want
to put it that way.

5

Q. Well, you used the word shortages,
as I recall it?

7

A. Yes.

8

9

10

Q. Certainly there were fewer nurses
on duty at night than during the day. But that's true
in any ward in any hospital, is it not?

11

12

A. Yes, it is. But we are dealing
with a sick group of patients.

13

14

15

Q. Well, I understand. Well,
perhaps we can get into that later with some nursing
specialist, forgive me. I didn't mean to be
argumentative with you, Doctor.

16

17

18

19

Now, the six children who were discussed
at the two meetings in September had another feature
in common, did they not? Each of them had been the
object of a resuscitation attempt by the resuscitation
team?

20

21

A. Yes.

22

23

Q. And, indeed, as I review the
charts, in the 10 deaths which had occurred on the
ward between July 1 and August 31, there had been

24

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2 seven Code 25s called, and those in the cases of
3 Bilodeau, Taylor, Turner, Dawson, Monteith, Shrum
4 and Velasquez, and all seven resuscitation attempts
5 had failed, had they not?

6

A. Yes.

7

Q. Is that an observation that you
8 made when you were looking over these cases for the
September meetings, Doctor?

9

10 A. We certainly realized they hadn't
been resuscitated.

11

12 Q. Did you have any concern there had
13 been, to put it bluntly, a hundred percent failure rate
with those attempts?

14

15 A. No, that didn't concern me. I
16 mean, it concerned me that we weren't able to get the
babies to survive, but it didn't concern me that the
resuscitation attempts failed.

17

18 Q. You told us I think on Tuesday
19 that there was now some information to suggest an 11
percent success rate with resuscitation on cardiac
20 wards and nowhere do you have that information?

21

A. Yes.

22

Q. Maybe 7 is too small a sample for
the overall average percent, but we can work it out.

23

A. Yes, I think it is very possible.

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Rowe, dr.ex.
(Lamek)

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Q. Now, we know there was to be another meeting after the September 26th meeting, it was going to be on a Monday and Dr. Jedeikin was going to arrange it. For what purpose was there to be another meeting held, Doctor?

A. Well, I thought that there were a number of advantages that came out of the first two meetings that would suggest we should continue this dialogue, in addition to the other measures that we took to look at the deaths. So, I thought that that probably should be something at least for the present we should continue.

Q. When did you contemplate that next meeting might be held?

A. I think it was - I can't recall exactly when we had a prediction at that time, but I think it was to be arranged during the next month.

Q. Now, in fact, as far as I am aware, there was not another meeting, a mortality/morbidity conference until January, but you were away during the fall, were you not?

A. Yes, I was.

Q. Late fall, early winter, and you were very far away, as I understand it?

A. I was.



Rowe, dr.ex.
(Lamek)

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Q. Back in New Zealand lecturing,

3 I think?

4

A. I beg your pardon?

5

Q. Were you lecturing back in New Zealand?

6

A. I was lecturing in Australia and New Zealand, yes.

7

Q. And when did you leave, Doctor, and when did you come back, approximately?

8

A. I haven't got the exact dates -

9

I think I have got the exact dates somewhere here.

10

Q. Roughly is what I am after.

11

A. Well, roughly, it was from the middle of October to the first week in December.

12

Q. Now, Doctor, from the middle of October then, in your absence, it appears that four children died on the ward: McKeil on October 15, Adamo on October 19 and Volk on October 23. And I take it from the rough times you have given me, you were away for each of those deaths?

13

A. Yes.

14

Q. And one child had died in November, that is to say, Matthew Lutes on November 17?

15

A. Yes.

16

Q. And there was not another on ward

17

18

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Rowe, dr.ex.
(Lamek)

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2 death that I am aware of until December 9, by which
3 time I take it you were back in town?

4 A. I was back by December 9, yes.

5 Q. And during the month of December,
6 from and after the 9th, there were five on ward deaths,
7 were there not?

8 A. Yes.

9 Q. That of Onofre on December 9,
10 MacDonald on December 13, Gosselin on December 18,
11 Lombardo on December 23 and Belanger on December 28?

12 A. 24?

13 Q. I beg your pardon?

14 A. Was it the 24th?

15 Q. I thought it to be the 28th,
16 Doctor, but we can confirm that.

17 I take it that upon your return you were
18 made aware, or you learned of the deaths that had
19 occurred on the ward in your absence?

20 A. Yes.

21 Q. Now, let's go back then to the end
22 of December. At that time, since your departure,
23 there had been an additional nine children die on the
24 ward; five of them in December. Did you observe, or
25 was it pointed out to you, that six of those nine
deaths and, indeed, four of the five that occurred in



Rowe, dr.ex.
(Lamek)

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December, had occurred in the early hours of the
morning?

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A. Yes.

5

Q. Is that something you observed or
something that was brought to your attention?

6

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A. That would have been at the daily
discussions.

8

9

10

11

Q. Now, as December wore on, from
the time of your return and the number of deaths
increased, what was your reaction to those incidents,
what did you think?

12

13

A. Well, I was becoming concerned
over the numbers in a large way at that stage.

14

15

Q. When you say in a large way, could
you try to tell me just what it was you were worrying
about at that point?

16

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A. Well, I was concerned about the
number of deaths and the fact that although we still
appreciated the severity of the disease in all these
patients, that it was an impetus to review the entire
group in considerable depth to see if there was any
conclusion we could reach about the numbers, the high
numbers.

22

23

Q. Were you, during the month of
December, beginning to question the conclusions or

24

25



Rowe, dr.ex.
(Lamek)

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opinions that you had formed in September as to the
cause of the deaths?

4

A. No. I think that we had perhaps,
at least my reflection on that on return was that the
numbers had reduced somewhat, and then as December
went on those numbers seemed to be rising again and
on a day by day basis that we examined this issue, it
seemed to me a reasonable matter that we should begin
to look in greater depth at the specifics of the more
recent deaths and then add those to the specifics of
the earlier deaths, try and reach some conclusions
about whether management issues should be changed in
any way.

13

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Q. All right. Now, were other staff
cardiologists or cardiac fellows expressing concerns to
you, or expressing them to your knowledge about this
same problem?

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A. Well, you know, I don't recall
specifically people saying to me, look here, Dr. Rowe,
we've got far too many deaths occurring on this ward
and so on, but obviously at the interchange we have on
a daily basis at these conferences, people were
concerned that we were having a large number of deaths.

22

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But I think there was no doubt that
everybody appreciated we had a large number of very



Rowe, dr.ex.
(Lamek)

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2 sick infants to deal with and I think that there wasn't,
3 to my knowledge, a major concern that there was mis-
4 management or anything that could be accounted for
5 this, other than the severity of the defects. /

6

Q. All right. To your knowledge,
6 were the nurses concerned about the ongoing deaths on
7 the ward?

8

A. I am not sure at that point
9 because I wasn't on the floor at that time and I would
10 rely for that sort of information from the cardiologists
11 who were. I didn't specifically approach the head
12 nurses, to my recollection, and say to them are you
13 concerned about this.

14

Q. Was it your information that they
14 were concerned?

15

A. That they were?

16

Q. That they were concerned?

17

A. I am not sure whether they were
18 concerned. I imagine they were.

19

Q. It would be pretty surprising if
20 they were not?

21

A. If they were not, yes.

22

Q. Well, we know that the Head of
22 Cardiovascular Surgery was concerned, Dr. George
23 Trusler?

24

25



Rowe, dr.ex.
(Lamek)

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A. Yes.

3

4

Q. Because he expressed his concern
to you, did he not?

5

A. He did.

6

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9

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Q. Doctor, I am showing to you what
appears to be a copy of a letter from Dr. Trusler to
you dated December 15th, 1980. This is a two page
letter and attached to it is a copy of a two page
letter apparently from yourself to Dr. Trusler dated
December 29th, 1980. Do you recognize those, please?

11

A. Yes, I do.

12

13

MR. LAMEK: May that exchange of
correspondence be the next exhibit, Mr. Commissioner?

14

THE COMMISSIONER: Exhibit 64.

15

16

--- EXHIBIT NO. 64: Letter from Trusler to Rowe
dated December 15, 1980,
and letter from Rowe to
Trusler dated December 29,
1980.

17

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MR. LAMEK: Q. Doctor, I am obliged
to ask you the very first question about this letter,
why it was written at all? Is this the normal way in
which you and Dr. Trusler communicate within the
hospital?

21

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A. We usually communicate verbally
but we also send letters or memoranda to one another
if we want to provide details of a specific issue.



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Q. I can understand certainly
talking to each other and I can understand memoranda.
But do you recall receiving a letter before Dr.
Trusler?

5

A. I think I have, yes.

6

Q. Do you recall having written him
a letter before?

8

A. Oh, yes.

9

Q. Rather than a memorandum?

10

A. Oh, yes.

11

Q. All right. On what sort of
occasion?

12

A. Oh, I have written to him I think
on matters about conferences or matters that I don't
feel should be necessarily part of the hospital record
that relate to working relationships between cardiology
and cardiac surgery and so on.

17

Q. And was that your explanation for
writing a letter to Dr. Trusler in response to his,
that you did not think this should be part of the
hospital record?

20

A. No, my letter demonstrates that
it can be part of the hospital record because I have
a distribution list.

23

Q. Yes.

24

25



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2004

Rowe, dr.ex.
(Lamek)

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A. It can't go onto a patient's
chart because it is not referring to a specific
patient.

3

Q. Yes.

4

A. But the distribution list is to a
wide number of people who are connected with the
hospital.

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2 Q. Very well, Doctor.

3 In Dr. Trusler's letter to you he
4 starts:

5 "AS I mentioned to you the other
6 day"

7 which I take it with piercing insight into the
8 obvious there had been an earlier discussion between
9 the two of you about some of the matters raised in
this letter?

10 A. I believe there must have been.

11 Q. Do you have any recollection
12 of the discussion?

13 A. No.

14 Q. I suppose it is a good thing
he wrote you the letter?

15 A. Probably that is why he wrote
16 it to me.

17 Q. All right.

18 As well as recalling that he mentioned
19 to you earlier he says bluntly:

20 "I am concerned by our relatively
21 high mortality. I think that it is
22 higher than it has been in previous
23 years. Much of this may be related
24 to increased complexity of operation

He was v.
concerned but
he didn't say
remember that
Trusler dis-
cussed his
problem w. him



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3 Q. And he goes on, sharpening
his focus a little:

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10 I pause there for just a moment.

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1 Q. "In particular, I am a little
2 concerned by the number of deaths
3 that occur back on the ward some
4 time after operation. That is, after
5 they have left the intensive care
6 unit, and at a time when we would
7 assume they are out of danger."

8

9 I take it, Doctor, am I right, that
10 if a child dies postoperatively, even many days after
11 surgery, but during the same hospital admission, he
12 is treated as a surgical death?

13 A. Yes.

14 Q. So the fact that a child has
15 apparently survived surgery, gone to the ICU, has
16 been discharged from the ICU, spent a number of days
17 back on the ward and then dies, he is still nonetheless
18 for statistical purposes and perhaps others a
19 surgical death?

20 A. Yes.

21 Q. Was it your understanding
22 from this letter that Trusler was concerned that the
23 surgical deaths were including children who, after
24

25



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2 surgery, seemed to be doing well, had been returned
3 to the ward and died there? Was that his concern
4 as you understood it?

5 A. He says that he is concerned
6 by the number of deaths that occurred back on the
7 ward some time after operation. That is what I take
from that.

8

Q. All right. He says:

9 "It may be that we are sending them
10 back too soon and I know that many
11 factors are involved, but I might
12 list a few of the cases just to show
13 you the size of the problem. These
14 are children who died many days after
15 their operation and in most cases on
the ward, I believe."

16

17 And the ones that he lists, the seven that he lists,
18 Doctor, the only one we have come to at this stage
19 in the review that you and I are doing now is that
of Velasquez?

20

A. Yes.

21

22 Q. He lists seven and expresses
23 his concern and says in effect if there is anything
24 we can do let's get together and see what the problem
25 is and see if we can resolve it.

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Now Doctor, on receipt of Dr. Trusler's letter what did you do?

A. Well, it was my recollection that we had arrived at this point almost in parallel because I believe that we already were starting to look at the population and gather the information together, but I don't know for sure at what date we started doing that in December, but it was some time in December.

Q. At that stage were you reviewing or were you about to review charts of recent deaths or had you instructed someone else to conduct such a review?

A. Yes. Dr. Jedeikin, the senior Cardiac Fellow and myself had met on this point and had decided on an approach to the problem which I further outlined I think in this letter.

Q. You replied to Dr. Trusler's letter on December 29th, 1980. There having been the intervention of Christmas and so on was there any other reason for there being two weeks elapsed between Dr. Trusler's letter and yours?

A. He might have been away skiing.

MR. LAMEK: A nice thing to be.

I want to get into that, but before

Why was T's
absence delayed?
R's response

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F.6

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2 I do, Mr. Commissioner, I wonder if this would be a
3 sensible time to take a short break?

4 THE COMMISSIONER: Yes. We will take
5 15 minutes.

6 MR. LAMEK: Thank you.

7 --- Short recess

(2) 8 --- On resuming:

9 THE COMMISSIONER: Mr. Lamek?

10 MR. LAMEK: Q. Dr. Rowe, if we could
11 come to your letter of December 29th written in
12 response to Dr. Trusler's letter - you have a copy
13 of your reply in front of you there?

14 A. Yes.

15 Q. If I may say so there is a
16 rueful quality, is there not, about the second
17 paragraph, the second sentence of your letter:

18 "We could I think without much
19 trouble amplify the list of seven
20 patients you gave us ...".

21 A. Yes.

22 Q. Including two within the week
23 preceding your letter.

24 You then go on to refer to the
25 mortality and morbidity rounds that you had held, the
two conferences in September, and it is your intention



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2 they should continue and you have told us why you
3 had that intention.

4 Can I just go back a moment now,

5 Doctor?

6 You said that upon your return from
7 Australia and New Zealand at the end of the first
8 week in December you learned of the further deaths
9 that had occurred.

10 You had also told us that it had
11 been your expectation that a further mortality and
12 morbidity conference was to be held in October,
13 perhaps. When you came back you found there had not
14 been a meeting since the one in September and there
15 had been no conference at all during your departure.

16 What was your response to that piece
17 of intelligence?

18 A. I was not particularly happy
19 to hear that because that was a problem of communica-
20 tion of some sort I believe.

21 Q. Yes.

22 A. It was known I think by
23 Dr. Jedeikin that he had that responsibility put to
24 him but for one reason or another he was unable to
25 accomplish it.

26 Q. You go on:

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"For the most part those patients
discussed have been non-surgical
patients ... "

3

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and had it been your intention to convene a meeting
involving surgeons as well at which postoperative
deaths should be reviewed?

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A. During the course of the
previous seven months?

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Q. Yes.

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A. No. The surgical patients
are reviewed separately. I mean we know when a
patient who is a surgical patient dies, and we look
at it ourselves, but they are reviewed by the
surgeons separately within their own division and
department, so that we feel pretty confident that if
there is some issue that concerns them particularly
about the surgery that they would come to us about it.

Q. And you go on to refer to a
couple of the benefits or useful matters that had
come out of the two meetings in September, the question
of the nice large type card of dosages on the arrest
tray on the resuscitation cart, and the "perceived
need of an immediate intensive care unit on 4A/B".

I am interested in the next sentence:

"It is my feeling that such a unit



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2 "should be seriously considered. -
3 particularly since most of the
4 patients we are talking about are
5 small infants at relatively high
6 risk for respiratory arrests and
7 who probably need a much higher
8 nurse-patient ratio than is
9 currently provided at nights on
that ward."

10 Now you have told us something about
11 that already, but of course I am interested in words
12 like "it is my feeling that it should be considered",
13 "they probably need a much higher nurse-patient ratio",
and so on.

14 Doctor, I am not in any way being
15 pejorative or critical about this. Was that a
16 matter of impression of yours or experience or was
17 there some data upon which that view as to the
18 relatively high risk of infants for respiratory arrests
19 was based?

20 A. No, I think that I would have
21 been meaning there that the small infant, the smaller
22 infant is more likely to have rapid deterioration than
the older child.

23 Q. Is that particularly true from
24

25



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2 your experience or is it your impression that is
3 particularly true --

4 A. Yes.

5 Q. At nighttime?

6 A. Well, I don't know that it is
7 particularly true at night but I think I was of the
8 impression that it would be more likely to occur at
9 night because of the fact that this is a high risk
group where the density of nurses decreases at night.

10 Q. All right. And you go on:

11 "Whether this should be officially
12 tied in with the ICU proper and have
13 staff attachment from that ward is
14 a matter for further discussion but
15 I think that the provision of such
16 a small unit might offer a solution
17 to some of these problems and that
18 its formation should be seriously
considered at this stage."

19 As of the date you wrote this letter
20 to Dr. Trusler, late in December of 1980, were you
21 satisfied that the problems had been defined?

22 A. The problems of the ward or
the problems --

23 Q. The problems of the ongoing

24

25



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2 deaths and the deaths that Dr. Trusler was
3 particularly concerned about in postoperative patients.
4 Had you really at the end of December having now
5 returned from your trip abroad and finding ongoing
6 numbers of deaths on the ward, were you really
7 satisfied that the problems had been defined
8 sufficiently for you to know what the possible
solutions were?

9 A. I don't think we could be
10 sure of all the reasons why that might have been the
11 case. We didn't have the sort of detailed statistics
12 on this at all. And that is really how we have to
13 work on a day to day basis, that we have to look back
14 over a short period and see what went on and see
15 what we think might be reasonable to look at further
16 and to try and evaluate that together.

17 Q. And you go on to refer to
18 some other possible causative matters, the early
19 transfer of patients from the ICU, and you have
20 already referred to that in your evidence, Doctor,
21 pressure for space there and so on, and can you help
22 me at the bottom of that page and the top of the
23 next one:

24 "We have had examples amongst these
25 deaths of patients in whom in the



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2 "intensive care unit the cardiologists
3 were very concerned about the
4 absence of a murmur and the very low
5 PO2 levels."

Now I merely ask you to explain,
please, the significance of the absence of a murmur
and low PO₂ levels. What is involved there?

0. Shunt?

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It is in effect an artifical ductus arteriosis.

3

Q. You hear the blood passing
4 through?

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A. You hear the blood passing
6 through this channel and it produces a murmur that
7 is described as a continuous murmur, it is a very
8 noisy noise.

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The second feature is the change in
the amount of oxygen that can be measured in the
blood of the artery of the individual, in the
systemic circulation. By that we mean that in crude
terms the baby is pink, or is pinker than he was
before the shunt. He may have been very blue before
the shunt but becomes at least mauve or somewhat
more in that direction.

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So, PO2 is the term for the partial
pressure of oxygen in blood and a low arterial PO2
would be a more precise way of judging the effect of
the shunt than just looking at the baby.

Q. As I understand your suggestion
that
/you are raising in the paragraph, is perhaps you
surgeons should be thinking about going back in and
making sure the shunt is working, we are not hearing
the murmurs and we are recording very low PO2 levels,
is that the message, is that what is coming out?



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2 A. Yes, I think obviously that
3 might be construed by the surgeon as a little over-
4 statement of the case. The point was to draw
5 attention to the possibility that there might be
6 reintervention in a borderline situation earlier
7 than perhaps we had been doing.

8 Q. And the other thing I confess
9 I do not understand, could you tell us briefly what
10 it is you are referring to in the next paragraph
11 phrenic-nerve palsy?

12 A. During the course of operations,
13 particularly of those that are involved in providing
14 a shunt procedure, but also in others, there may be
15 injury introduced to the phrenic-nerve which supplies
16 the diaphragm. That nerve, if it is injured it will
17 become paralyzed, the muscle will become paralyzed,
18 I am sorry, not the nerve, the muscle of the diaphragm
19 becomes paralyzed and that can seriously interfere
20 with the function of breathing, particularly in a
21 small baby. It is not too much of an insult for an
22 older individual, but for a small baby it can be
23 quite critical. So that some babies who develop
24 that complication at operation can have tremendous
25 amount of respiratory difficulty and have to be
 ventilated for periods for as long sometimes as



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several weeks.

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Q. Is it the diaphragm not
moving that restricts the ability of the lungs to
expand?

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A. Yes, the diaphragm moves in
a paradoxical fashion. On one side where it is
paralyzed it goes up when the diaphragm should go
down.

9

Q. I see.

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A. So it gets like that, and

it really interferes rather seriously, particularly
in small babies with their ability to exchange air.

Q. All right. So if I can

summarize it fairly, you acknowledge the concern,
and you say these are things that we have been
talking about, and I think there are a couple of
other things that maybe you should be concerned
about with your people, and you want to talk about
that, and maybe you should all have a meeting
together and discuss this thing. Is that essentially
the message that comes out of this?

A. That is.

Q. It was proposed that the

meeting be held early in the New Year. There is
an interesting list of persons to be present, yourself,



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2 Dr. Trusler, the two Head Nurses, the Area Nursing
3 Co-Ordinator and the Administrative Ward Chief for
4 4A/B. Why that selection of people?

5 A. Why did I select those
6 people?

7 Q. Yes.

8 A. Well, I thought that any
9 decision about these matters would have to and
10 properly should include nursing personnel, and
11 obviously the Head Nurses of the Ward would be
12 appropriate. We recognize that in inviting the
13 Area Nursing Co-Ordinator she might want to have
14 other people, and indeed that proved to be so, and
15 we obviously wanted the surgeons to be both there.

16 I think in further discussion about
17 this we also introduced an obviously important
18 individual for such a conference, somebody from the
19 Intensive Care Unit who would have to give his
20 opinion on whether this was a valid objective, or
21 whether there were points that couldn't be managed
22 by it and we would have to find some other solution.

23 THE COMMISSIONER: I missed out,
24 who is Dr. Trusler?

25 THE WITNESS: Dr. Trusler is the
26 Head of the Cardiovascular Surgery Division of the



G5

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2 Hospital.

3 THE COMMISSIONER: I know there is
4 a great deal of co-operation, is there any chain
5 of command between you and Dr. Trusler?

6 THE WITNESS: No. He is in an
7 entirely separate department of the Hospital.

8 MR. LAMEK: Q. He reports to the
9 Department of Surgery?

10 A. He reports to the Department
11 of Surgery.

12 Q. And you report to the Department
13 of Pediatrics?

14 A. And I report to the Medical
15 Department of Pediatrics.

16 Q. Before I get to that meeting,
17 Doctor, I think there is one thing that I think I
18 should properly go back to and that is the question,
19 forgive me for taking it out of order and disrupting
20 the chain of thought, the question of resuscitation.
21 We mentioned that briefly just before the break and
22 I pointed out to you that the ten ward deaths that
23 occurred, that there had been resuscitation attempts
24 for seven and all seven had been unsuccessful.

25 I take it there were during the 9 month
26 period which concerns us, some successful



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resuscitation attempts?

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A. Yes, there were.

4

5

Q. And you have told us of the -
your information as to the ongoing success ratio of the
Resuscitation Team on the Cardiac Ward and I think you
said it is about 11 per cent.

6

7

A. No, that figure comes from
data that is obtained during the period under
discussion from March of 1980 to - at least from
July 1980 to March 1981.

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Q. So in that year, which
includes the period with which we are concerned,
of all resuscitation attempts undertaken there was
an 11 per cent success ratio?

15

A. Yes.

16

17

Q. And some of those obviously
fell within the period with which we are concerned?

18

19

A. Yes, and that ratio is
approximately the ratio that is found in success
in resuscitation in most experiences in hospitals.

20

21

Q. Good, and I think it is as
well that that is cleared up, I didn't want to leave
the wrong impression about that.

22

23

A. Thank you.

24

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Q. Now, sir, can we go back to the



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point of the ongoing narrative here?

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The meeting was to be arranged in the early New Year. I have already explored with you to some extent the nature of the concern that you were now feeling about this ongoing increase in the number of ward mortalities.

You were now aware I take it of some 21 or so deaths that had occurred between July 1, 1980 and December 29, 1980 on the wards. Although you may not have received the number, I take it from what you said you were aware that a substantial proportion of those had occurred in the early hours of the morning, and indeed by my count, Doctor, I total it to be some 14 out of the 21 occurred between 1:00 a.m. and 5:00 a.m.?

A. Yes.

Q. Without knowing perhaps the precise numbers you were aware of that pattern, were you?

A. Yes.

Q. Now, was that pattern of distribution of the deaths around the clock, would it in itself cause or add to your concerns?

A. I think I would agree it must have, because we kept on commenting about this in

They recognised the pattern. They were concerned about it but their canvassing of the possible reasons for it produced only an impression that the wards were understaffed with nurses at night — an impression which was unshaken by any allegation to that effect by the nursing staff and which they did absolutely nothing to check!

"A proportion"? 14 out of 21 die between 1 a.m. - 5 a.m.?



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relation to the nursing cover at night. I don't recall that we sat down and said, my goodness, there is this many between 1 o'clock and 3 o'clock, I don't think we ever did anything like that. But on the day to day basis it was apparent that many of them were at night and that I think led into the question of possible reasons why that might be.

Q. But you had not yet, as I understand you, you had not yet made any association or attempted to discern any association between nighttime deaths and the presence of particular people, particular nursing units, or other people on the ward, residents on duty, that sort of thing?

A. No, because I think we all recognized that you are going to have a proportion of patients who die at night. Although we didn't have figures on that basis from the Hospital and it remained for others to get those figures with their computers and other rather extensive efforts to put the times together for a large number of deaths, nevertheless we thought that one should expect a considerable proportion of patients to die at night.

Q. Doctor, it may not be the kind of exercise that one can readily find the time to perform in the middle of a busy clinical practice,



G9

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2 but in your consideration of the increased mortalities
3 ward mortalities that you were experiencing, would
4 it not have been helpful for you to know of the
5 clustering that appeared to be occurring between
6 1 o'clock and 5 o'clock in the morning?

7 A. I suppose it might have been
8 but I am not sure.

9 Q. Well, would that not have
10 produced a more refined focus than merely children
11 are dying at night, which as I understand it was
12 your perception?

13 A. Yes.

14 Q. After all, one can assume,
15 I suggest to you, that since there are 12 hours of
16 day and 12 hours of night you expect a roughly
17 equal number to be dying in each 12 hour block?

18 A. I think that is not unfair.

19 Q. But if you found in fact a
20 very substantial percentage was dying in a four-hour
21 time period that might, might it not, put a rather
22 different complexion upon the analysis?

23 A. Well, I think that would
24 depend on the numbers involved and you might need
25 a larger number to reach that conclusion than the
number of deaths that we are talking about here,



Rowe, dr.ex.
(Lamek)

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which is 20.

3

Q. Doctor, in relative terms
we are talking about three years worth of ward
deaths, are we not, 20?

6

A. Yes.

7

Q. Your average death rate ---

8

A. Yes, but the ---

9

Q. --- over nine months?

10

A. The total number I am talking
about in relation to that sort of observation.

11

Q. Yes.

12

A. Is only 20.

13

Q. I am suggesting to you,

14

Doctor, that was a very substantial number, was it
not?

15

A. It is a substantial number of
deaths but I question whether it is a large enough
number to make detailed analysis of the time, the
timing of death.

19

Q. Is it not a piece of information
which might reasonably have caused you to make
enquiries as to why - as to whether indeed there was
any significance to that clustering, and if so what
might be causing it?

23

A. I think today you might take

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that position but at the time we did not.

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Q. You were still nevertheless at the end of December concerned to know why these high numbers of deaths were continuing, were you not?

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A. Would you repeat that, please?

7

8

Q. Yes. You were still concerned at the end of December to know why the deaths were ongoing?

9

10

A. Yes.

11

12

Q. And you have told me that your concern then was perhaps deeper or sharper than it had been at the beginning of September?

13

14

A. Yes.

15

16

17

Q. I take it from what you said earlier at least the possibility of mismanagement of the patients had occurred to you as a possible explanation?

18

19

A. A very distant possibility.

20

21

Q. Whether that be mismanagement by physicians or by nurses. Why was that so distant a possibility, Doctor?

22

23

24

A. Because we had reviewed as we went through the nature of the malformations, the nature of each death and we hadn't in my view come

25

Incredible! Rave is the head of the Division. He returns from a 6-7 weeks absence to find:

- (a) Large numbers of on-wand deaths are still occurring.
- (b) many of the deaths are occurring at night
- (c) the Dr. Cardiac fellow, who was to have arranged follow-up M-M conf in Rave's absence has done nothing and Rave can't even remember if any cardiologist in his division ~~ever~~ spoke to him about possible explanation for the situation!



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up with any obvious factor that would suggest mis-
management.

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Q. I am certainly not suggesting
that you should at that stage turn your mind to the
possibility of foul play. Did you not entertain
the possibility of some unintentional mismanagement
as a possible explanation?

5

6

7

A. We wanted to look at that
question, but we didn't really think that that
was the case, at least as a result of our preliminary
day to day discussions that had not really emerged.

8

9

Q. Had you in the period from
the date of your return - I think you said the end
of the first week in December to the end of December,
in that three weeks, had you had any discussions with
any of the staff cardiologists about the possible
explanation for the continuing on ward deaths?

10

11

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A. I think we probably did but
I don't recall, I didn't have a specific meeting
addressing the topic as such, but undoubtedly there
would have been discussions about that because when
I came back I was informed of it.

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Rowe, dr.ex.
(Lamek)

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Q. Do you recall any discussion with
any of the cardiac fellows about possible explanation
for the ongoing high mortality on ward?

3

4

A. I don't recall.

5

Q. Or with any member of the nursing
department, nursing specialist, head nurse, director,
assistant director, floor nurse?

6

7

A. It doesn't strike me as a major
interview or anything of that sort.

8

9

Q. Do you have any recollection of
any discussion, conversation, exchange with anyone
else in the hospital other than Dr. Trusler and the
exchange of correspondence that we have seen, as to
the possible explanation for the ongoing situation
as you found it in December?

10

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A. I don't remember the discussions
that I might have had with other people. Certainly no
specific formal meetings were held. But I must have
spoken to Dr. Edmonds.

19

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Q. Doctor?

A. Edmonds.

Q. Is he the intensivist?

A. He is the intensivist, yes.

Q. Yes. But you don't recall?

A. No, I don't recall exactly the



1

2 circumstances that I would have done that, but I must
3 have spoken to him because I invited him to the
4 meeting and I must have talked about the background
- of the reasons for the meeting.

Q. Yes. Did you continue to have
the impression as at the end of December that the
severity of illness of your patient population was an
explanation for the continuing high level of on ward
~~mortality~~
activity?

10 A. Yes, I did.

11 Q. And did you continue to have the
12 impression as at the end of December that there was,
13 what you have earlier said, a shortage of nursing on
14 night duty in the cardiac wards and that that might
15 be part of the explanation for the ongoing high
mortality?

16 A. I think all of these factors
17 entered into my thoughts at that time.

Q. You continued to hold those views?

10 A. Yes.

20 Q. Now, as I understood you on
21 Tuesday, Doctor, talking about those impressions that
22 you had at that time, you referred to clusters of
23 particular kinds of deformities, seriously ill patients,
that sort of thing, and I think in the context of



Rowe, dr.ex.
(Lamek)

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2 possibly regarding the deaths in July and August as
3 a manifestation of a cluster of seriously ill patients
4 resulting almost inevitably in a number of deaths.
5 I accept that such clusters can occur and they are
6 recorded in the literature.

7 Do I correctly characterize what you are
8 advancing as a possible explanation the impression that
9 we had particularly seriously ill patients who were in
10 a sense clustering, there was an unhappy concatenation
11 of these poor patients resulting in higher mortality?

12 A. Yes.

13 Q. Did you continue to be of that
14 view, that what you were seeing as a clustering of
15 seriously ill patients as at the end of December?

16 A. I thought that was still a
17 possibility, a good possibility.

18 Q. If there were a clustering of
19 seriously ill patients, Doctor, would that explain why
20 deaths were occurring on the ward because, as you have
21 told me, the ward is not the place where children
22 usually die? It might explain a high number of deaths
23 from those of whom you have admitted, would clustering
24 of seriously ill patients explain a large number of
25 on ward deaths?

A. It could.



Rowe, dr.ex.
(Lamek)

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Q. It could. Would it be more likely
to produce a higher number of children who died either
in the operating room or in the ICU?

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A. I think that's a fair statement,
assuming that a good number of those seriously ill
babies would have conditions that are amenable to
surgical intervention, yes. But some of them would
not.

Q. Would the cluster idea explain
the, what I will call the overlaid cluster of a large
percentage of deaths occurring in the middle of the
night?

A. It might if they were severely
ill babies, yes. I think that is definitely one
explanation that could be advanced.

Q. The suggestion is that severely
ill babies tend to die at night?

A. I think that would be more likely
if they were not as closely monitored at night as
during the day, they would be more subject to this.
They would be a higher risk I think.

Q. Doctor, do you have any reason to
question or dispute the information that was produced
here on Tuesday morning as to the number of deaths that
have occurred on those wards in the middle of the night



Rowe, dr.ex.
(Lamek)

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over a three year period?

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As I recall it, in the 18 months immediately preceding the nine month period in which we are interested, there had been one death between the hours of 1:00 and 5:00 and in the succeeding 18 month period there had been one death between the hours of 1:00 and 5:00. Now, it may be that that time span was not long enough. Will you agree with me that on the basis of that information at least, it does not suggest that children on the cardiac ward tend to die in the middle of the night?

11

A. On the basis of that information presented, yes.

12

Q. Do you have other information which would lead you to challenge the validity of that?

13

A. I don't have that information, but one would like to see more extensive analysis.

14

Q. Yes. Now, if indeed as from the data that we do have it appears that there is a degree of unusualness about a question of deaths in the middle of the night, then that would constitute, wouldn't it, two clusters coinciding on your impression of this case: a cluster of seriously ill patients and a cluster of the deaths of those patients on the ward at a

24

25



Rowe, dr.ex.
(Lamek)

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2 particular time of the night?

3 A. Yes.

4 Q. And will you agree with me,
5 Doctor, that would be a rather unusual situation to
6 encounter, would it not, the coincidence of clusters?

7 A. I don't think that the two are
8 necessarily separate. I think one might depend on
9 the other, such as the severity of the illness and
10 that might be the reason why you got more deaths
11 occurring.

12 Q. Yes.

13 A. And the severity of the illness
14 might indicate that the monitoring situation might
15 explain that more deaths occur at night.

16 Q. Well, unhappily we don't have
17 statistics to establish that more deaths occur at
18 night or even that very many deaths occur at night,
19 but perhaps those statistics might be available,
20 Doctor.

21 A. Yes.

22 Q. Can we come to the meeting of
23 January 12th, 1981? Did you chair that meeting?

24 A. Yes, I did.

25 Q. And did you prepare minutes of the
26 meeting?



Rowe, dr.ex.
(Lamek)

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A. I did.

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Q. And I am showing to you what I understand to be a copy of the minutes. I will ask you whether the final page in this document that I have is part of the minutes, because although it is attached to the document that I received, it is dated some 15 months later. So, if it was not, perhaps you can tell me and we will take that off.

A. The last page of this document does not belong to the minutes.

Q. But the rest of the minutes are as you prepared them?

A. Are there, yes.

Q. Thank you. Then we will detach the last page and ask that the minutes as identified by Dr. Rowe be the next exhibit, please?

THE COMMISSIONER: 65.

---- EXHIBIT NO. 65: Minutes of meeting of January 12th, 1981.

MR. LAMEK: Mr. Commissioner, perhaps I should make it clear. The last page which has been detached but which may have been distributed with the real minutes to Counsel and others is a list of names alphabetically arranged bearing date in the lower right-hand corner, April 15, 1982. That is not part of the exhibit and was not part of the minutes of the



Rowe, dr.ex.
(Lamek)

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meeting prepared by Dr. Rowe, as I understand it.

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Q. Doctor, the minutes describe this conference as a luncheon conference. Do you recall how long it lasted?

4

5

A. No, I don't recall how long it lasted but I can guarantee you that it was more than one hour.

6

7

Q. Was it more than three hours?

8

9

A. I don't know. I don't think it would possibly go on that long. It would be a couple of hours in my estimate.

10

11

Q. Right. Indeed, it was truly a lunch conference, it didn't take up the afternoon as well, is your recollection?

12

13

A. Correct.

14

15

Q. Okay.

16

17

A. Well, that's a longer lunch conference than we usually have.

18

19

Q. Well, I know, but lawyers think in more expensive terms, Doctor.

20

Were individual deaths actually discussed at this meeting?

21

22

23

A. No, individual deaths were not discussed at this meeting because we had prepared the data prior to the meeting.

24

25

The founders of the city want to review deaths anyway. Rose saw it as a way of those who could advance the proposal for an intermediate ICA.



Rowe, dr.ex.
(Lamek)

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2 Q. Certainly as I read the minutes,

3

4 Doctor, I had the impression that they were telling
5 me that results of a prior review of deaths were
6 prepared and presented to the meeting as a taking off
7 point for the discussion of certain suggestions. Is
8 that a fair characterization?

9

10 A. That's a good characterization.

11

12 Q. If there then is what occurred,

13 I take it that in advance of this meeting you, I
14 assume, ~~with~~ ^{for} the assistance of other staff cardiologists
15 and fellows, reviewed or discussed and categorized
16 the deaths and then presented numbers by category to
17 the meeting?

18

A. Yes.

19

20 Q. Do you recall whether at the
21 meeting there was any question raised with respect to
22 any one of the deaths?

23

24 A. I do not believe there was any
25 question.

26

27 Q. Okay, Dr. Trusler didn't say, well,
28 come on, what about old so and so, we shipped him back
29 in fine condition, none of that stuff at this meeting?

30

A. No.

31

32 Q. All right. Were questions invited
33 about the review results that you put before the meeting?

34

35



Rowe, dr.ex.
(Lamek)

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A. I don't recall that I specifically
invited questions, but knowing the population that I
was addressing, it is unlikely that if I hadn't
invited they would have refrained if they had felt
the necessity.

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Q. Do you recall whether anyone did
ask questions or make comments about the analysis of
deaths that was presented to the meeting?

9

10

A. No, I don't recall that there was
any major dissent.

11

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Q. All right, then I will come back
later to the manner of characterization. Perhaps we
can look at the minutes. You have told me that you
prepared these. That, Doctor, makes me very interested
in the first sentence, after the list of persons
present, because now I can ask you what you mean by
"unexpected deaths"?

17

18

A. Well, we are back to unexpected
and expected.

19

20

Q. But this time you used it. What
did you mean by it?

21

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A. Well, we arrived at that
definition of unexpected for the purposes of this
discussion and we said that in patients who had an
expected death we would feel that the reason would be



Rowe, dr.ex.
(Lamek)

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2 that the patient had such a severe anatomic
3 abnormality functional disturbance that it would not
4 be expected that he could survive. So that the death
5 of that patient was inevitable.

6 Q. You are referring to what is
7 set out as Expectation Codes on the fifth page of
this document, Doctor?

8 A. Yes.

9 Q. You scored each of the deaths -
10 and I want to come to this later - in terms of whether
11 it was expected or unexpected; expected being in the
12 light of the degree of specific anatomic abnormality?

13 A. That's what expected means. So,
14 that meant death was inevitable. All other deaths,
15 for the purpose of this review, we called unexpected.
16 That was the reason. The reason for that was that we
17 wished to do an analysis of the causes of death in a
very critical fashion.

18

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of course! If all the deaths were
"excluded" (i.e. totally inevitable in
light of the cardiac anatomy) there
is no case for an intermediate ICU.
Raos's defⁿ of "unexcluded" suggests that
many of the deaths might have
been preventable, if only!



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A. There were patients amongst
the group that we placed as unexpected where there
might be differences of opinion amongst people as
to whether or not that is a true categorization.
Nevertheless we wanted to lean over in a direction
that would likely end up in a more appropriate
evaluation of the factors influencing death.

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Q. Let me just inquire about
that, Doctor.

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Was there not a time element in the
application of that expectation code? May I put this
to you: that if I am told that I have inoperable
and terminal cancer, then my death can reasonably be
said to be inevitable from that cause?

A. Yes.

Q. And when my physician may say
to me I will give you six months, he is projecting
a life expectancy based upon my clinical and disease
condition and if I were to die tonight of that
condition in a very real sense my death from that
cause, although properly described as inevitable,
would at the time it happened I suggest be
unexpected, wouldn't it?

A. I think you can make that
definition. I am simply saying what we used in this



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2 categorization in an internal review.

3 Q. All right. And therefore
4 you are telling me that a time element, the time of
5 death was not an ingredient in your classification
6 of expected and unexpected. I want to be clear?

7 A. Not necessarily.

8 Q. Well, was it at all?

9 A. If in the sense that the ones
10 we put in the expected category were inevitable,
11 there were a variety of times that we might have
predicted.

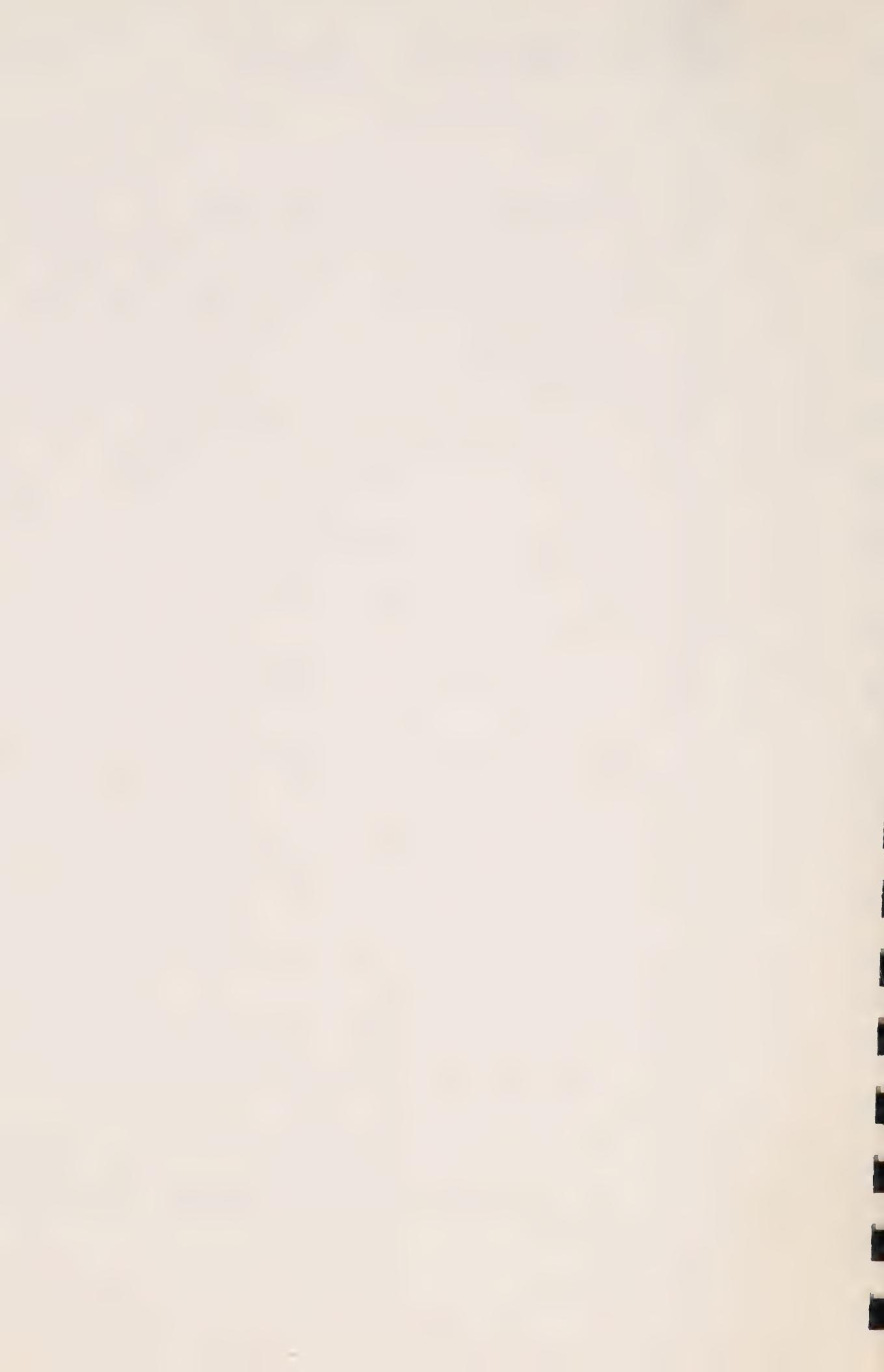
12 Q. I am sorry, I don't understand.

13 A. Well, we might have predicted
14 the death in one or two of the patients to be within
15 days and others that we might have ordinarily
16 predicted to be longer. But the death would have
17 been inevitable. So for the purposes of this
18 classification we called them expected. So the time
19 element might be variable in that group of patients
that we call expected.

20 All other patients we regarded as
21 unexpected, and I suppose the same consideration
22 might be made of that group.

23 Q. Well, I am sorry, I am no doubt being
24 very thick about this, and I ask you to bear with me,
Doctor.

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If, therefore, a patient had a set of anatomic abnormalities which would inevitably cause his death, if there was no intervention I take it, or are you saying where no intervention was possible?

A. Where we didn't think it was possible to achieve anything.

Q. Oh, I see. Where there was no intervention possible and those symptoms will cause his death which may occur today or a week or a month from now, that is an expected death according to the criteria which you established?

A. Which we used for this, yes.

Q. Yes. If, on the other hand, there is a possibility of intervention so as to avoid or defer a death which would occur inevitably in the absence of intervention, and death occurs in that situation, you would call that for this purpose an unexpected death, would you?

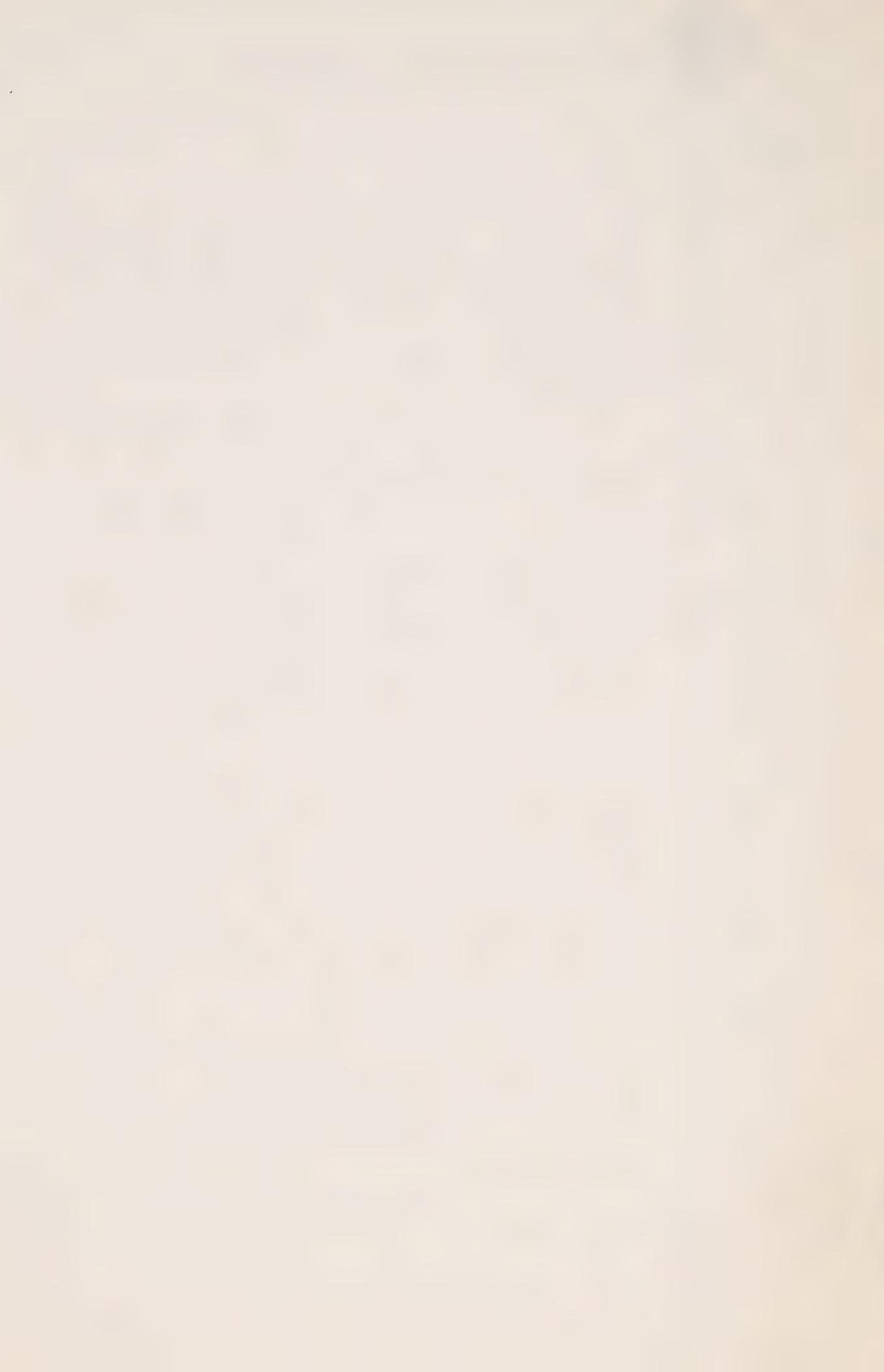
A. Yes.

Q. All right. I just wanted to be sure that I understood the terms.

Was that made clear to everybody at the meeting?

A. I believe it was.

11
bit!





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Q. Did people ask you what you
meant by expected and unexpected?

4

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A. I think they accepted the way
that we had done it.

6

7

Q. All right.

A. And I presume that everybody
was agreeable.

8

Q. You start:

9 "The apparent increase in the number
10 of unexpected deaths on the cardio-
11 surgical ward of both medically and
12 surgically treated patients since
13 July, 1980, led to the establishment
14 of mortality and morbidity conferences
15 in September and October of that
16 year ...".

17 I am not concerned about the reference to October. I
18 know there wasn't one.

19 Was there still at the time you
20 composed these minutes, Doctor, some question as to
21 whether there had been an actual and real increase
22 in the number of unexpected deaths?

23 A. No, I think not. By that time
24 we were clear that this was a large number.

25 Q. Was there any meaning that you
intended to convey by the use of the words "apparent
increase"?



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A. I think it may have been because of the grouping of expected and unexpected that we had classified perhaps more in the unexpected deaths than if we had just been doing a non-formal review.

This, as I have said, was to try and push as many patients into the unexpected group as we possibly could in order to make the analysis of the questions surrounding deaths to see if there weren't any other things we might or might not have done.

Many of those patients in that unexpected list, as you can see, were patients in whom there was terribly serious disease where it could be questioned whether you should not transfer them to the expected list, but we tried to avoid that problem so that we could really make as detailed an analysis as possible.

Q. Okay. You say half way through the first paragraph of the minutes:

"It is anticipated that similar conferences will be held at intervals where indicated on a more or less regular basis."

Were any such - were any further



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2 such meetings or conferences ever held?

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4 A. No, we didn't have any at
5 that time. This really constituted the next one,
6 but we didn't have any conferences on that line until
7 quite recently.

8 (2)

9

10 Q. I am sorry, which constituted
11 the next one?

12

13 A. Well, this one.

14

15 Q. Oh, I see. There was not one
16 after that?

17

18 A. No.

19

20 Q. You then refer to the two
21 recommendations that had come out of the September
22 26th meeting, both September meetings, but essentially
23 September 26th, legible dosage cards on the crash
24 carts and proposal for meeting about the intermediate
25 ICU.

26

27 Can we go to Item No. 1 at the foot
28 of page 1 of the minutes?

29

30 You itemize in the enclosure the
31 deaths on Wards 4A and B, July 1 to December 31, 1980.

32

33 Now the minutes say there were 22 of
34 those. I take it when I get to the enclosed list
35 which contains 20 names that you have removed already
36 the two which you say we really don't have to worry
37 our heads about?

38



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2 A. Yes.

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Q. And as always inevitably happens when one starts into a numbers game, I tell you, Doctor, as you know, information available to me is that there were really 21 such deaths, and maybe at a later stage we can compare our lists?

A. I can clarify that when you need it.

Q. All right. Now which of the 22, Doctor, were the ones described at the top of page 2? That is to say terminal and expected deaths from cardiomyopathy and from pulmonary vascular disease. Which were those?

A. These were Perreault, Taylor, Turner --

Q. No, we are talking about two at the moment I believe.

At the top of page 2 of the minutes you say deaths on 4A and B for the six-month period were 22 in number. Two of these were terminal and expected deaths --

A. Oh, I am sorry.

Q. -- from cardiomyopathy and from pulmonary vascular disease. So we have only got to worry about --



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2 A. Yes.

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Q. Yes.

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A. And were there on the ward

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expecting - we were expecting their deaths.

6

Q. Yes. I am not quite sure
why they are excluded from the total number of deaths
that need to be considered?

8

A. They are not excluded from the
number of deaths that are being considered. They are
just excluded from the detailed analysis that we
chose to take with reference to the patients who had
really congenital heart disease. They are a different
sort of heart disease.

13

Q. I see. I see. In other words,
I guess it is my failure to read between the lines.
What you are really concerned about, if I understand
you now, is deaths on the ward among patients with
congenital heart disease?

18

A. Yes.

19

Q. Why? Why are you not concerned
about all deaths on the ward?

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A. Well, we are, of course,
concerned about all deaths on the ward, but in this
sort of death there is no surgical intervention that
can possibly be made. And we did not think they

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2 fitted appropriately into other - examination of
3 other congenital heart malformations which is the
4 bulk of what is put onto that ward.

5 Q. All right. My misunderstanding
6 of the scope of the thing.

7 But it is implicit in the statement
8 that those two, Murphy and Heyworth, were terminal
9 and expected deaths, that the cause of their deaths
was their respective disease state?

10 A. Yes.

11 Q. That is implicit in saying
12 they were terminally ill of these particular things;
13 death was inevitable with them; we don't have to
14 worry about what killed those two?

15 A. Yes, and they were different
16 from the other patients.

17 Q. But different or not, were you
18 really saying any more about those two than that
19 their deaths and the time and the manner of their
20 deaths and so on were consistent with their clinical
21 disease condition?

22 A. Yes.

23 Q. And those charts have been
24 reviewed to enable someone to come to that conclusion?

25 A. Yes.



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Q. So therefore we come to a number of 20 deaths that were to be considered, and it is reported that their ages range from 9 days to 12 months; 9 of them were neonates. I am sorry, my memory is awful, Doctor. The definition of neonate is less than a month?

A. About a month.

Q. One month?

A. A month or less, yes. Thirty days or so, less.

Q. And of the 20 it is recorded that approximately a quarter of the deaths were such as to be expected?

A. Yes.

Q. We have to say approximately a quarter because the number may be four or five. There was a bit of question about Turner, was there not?

A. Yes.

Q. And that means in terms of your definition in the case of four or five of these children their deaths were not only inevitable in light of but consistent with their anatomical deformities and defects?

A. Yes.



I.12

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Q. Who were those five, please?

3

A. Those five were - they had

4

surnames of Perreault, Taylor, Turner, Monteith and
Gitten.

5

Q. Gitten, yes. Turner, perhaps
there was some question as to whether he was expected
or unexpected by this definition?

6

7

A. Yes. We put him into one - we
started off with him on 2, and we eventually put him
into the expected category.

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Q. He was eventually put into the
expected category you say?

11

12

A. Yes.

13

Q. All right.

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Q. So we have now approximately -
not approximately but exactly 5 of the 20 are expected
by the definition that you have given, but once again
that does not mean that any judgment was formed that
their anatomical conditions caused their death but
rather their deaths were entirely consistent with
and inevitable in light of their anatomical conditions.

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A. This is, you are referring now to the 20, the entire 20?

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Q. I am referring to the five, the expected ones. It means no more than this does it that the deaths of those children were inevitable in light of their anatomical conditions and were consistent with their anatomical conditions?

5

6

A. Yes.

7

8

Q. It does not mean, nor is it ever intended to mean, I take it that their deaths were caused by their anatomical conditions. Because that would introduce a temporal element into the thing, wouldn't it?

9

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A. I don't follow that question at all.

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Q. If I have terminal cancer and I am going to die tomorrow morning but someone shoots me in the head tonight, on your coding you have put me down as an expected death from cancer because it is inevitable and it is going to happen and no intervention is possible, but it is not what caused my death, is it?

A. Except as far as I know nobody has ---

Q. That is not what I asked you



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whether you knew it. I am only saying that on your classification definition it means no more than that, the death of these children was bound to occur in light of their anatomical condition, and their death is consistent with that anatomical condition?

3

A. Yes.

4

Q.. And fairly, *having* no reason to

5

suspect anything other than their cardiac defects as causing their deaths, [you know, without necessarily taking it,] I take it you are prepared to accept that the defects caused their deaths?

6

A. Yes.

7

Q. The remaining 15 you say:

8

"Death was not expected on the ward."

9

Now, again, can you explain to me what that means.

10

Because now into the definition of "expectation" you have introduced a geographic content?

11

A. Yes.

12

Q. Now did the geographic content enter into your definition of "not expected"?

13

A. We reached that comment,

14

I believe, from a division of those 15 patients into some who had come back from the operating room, and some who we expected might get to the operating room but did not; or, that we considered that was a

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reasonable assumption. Again I emphasize that we were taking the extreme position in this analysis in order to try and see whether there were things that should or should not have been changed.

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reasonable assumption. Again I emphasize that we were taking the extreme position in this analysis in order to try and see whether there were things that should or should not have been changed.

Q. Well, let me be clear to you. Were you meaning this, that because of the possibility of intervention to save those children from the results of their anatomic defect, or deformity, some of them should not have been on the ward at the time they died. Perhaps some of them should have been in surgery, perhaps some of them should have been in the ICU, some of them should have come back from surgery by that time. Is that the geographic ---

A. That was the thrust of our

argument.

Q. Okay, if they were going to die anyway they should have died either during or after some surgical intervention attempt. Is that the sort of thought?

20

21

22

23

24

25

A. I think that was the position we were taking. We were putting up a proposal to examine that question whether that was valid or not.

Q. And those are the children

who are identified as the two in the listing at the end of the minutes, other than Turner who was



J4

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transferred into the one category?

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A. Yes.

4

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Q. Now, you remember, Dr. Rowe, that you and I played the definitions game yesterday on the question of "expected" and "unexpected".

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Okay, you are in control of this one because you define ~~in~~ your own terms here. It follows I take it from your definition of "not expected" or "unexpected", that Bilodeau falls into that category. Although you and I had something of a difference about the expected or unexpected nature of that baby's death yesterday.

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A. I think that again I would

emphasize that the definition we used here might not necessarily be the definition we had used in the course of the day to day conferences. This was a very specifically oriented definition of unexpected.

Q. Yes.

A. To try and include as many patients in that category as we possibly could. If we look at Bilodeau, or if we look at Shrum, we are dealing with questions that do not necessarily mean that those patients deaths could have been avoided, or we might change our classification.

Q. Isn't that exactly what you are

*Get your
life in order!*



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2

saying by putting him into that category? You are conceding the possibility that there could have been intervention to prevent the deaths.

3

4

5

A. It depends upon the long-shot nature of your consideration, but indeed we did do that.

6

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Q. That is indeed your definition of unexpected, isn't it?

9

A. Right.

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Q. And therefore the question of whether they should or should not have died, could or could not have been retrieved, saved, repaired, recognizing always the variation in odds that can occur with any particular child who has a particular deformity is indeed part of this, even your definition of unexpected, isn't it?

A. Yes.

Q. Does that differ very greatly from unexpected as I was putting it to you the other day, or yesterday: that unexpected means, you know, gosh, we scheduled this kid for surgery, we expected him to survive until he got to surgery. We didn't think he was going to die last night. Is that very different?

A. Well, I think looking at this



J6

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2 group again I say that the - we might have different
3 definitions for Bilodeau or Shrum in terms of the
4 day to day conference, but for this particular
5 purpose we are putting them into a category where
6 we say they need not have died before they came to
7 surgery perhaps.

8 Q. In formulating the definition
9 of expected, was there any discussion between yourself
10 and Dr. Freedom?

11 A. We had many discussions about
12 this.

13 Q. In formulating this one for
14 the purpose of this meeting?

15 A. I don't recall specifically
16 but I believe that we did do the categorization
17 together. So I presume that we did have a lot of
18 discussion about it.

19 Q. You would hardly have expected
20 Dr. Freedom to have applied what you call his very
21 special definition unless he was aware of it.

22 A. No.

23 Q. Of what it was?

24 A. I don't recall having a
25 formal session about that, but I am sure we must have
discussed it many, many times because it is of course



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a recognized difficult area of a definition.

3

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Q. Do you recall any comment
from Dr. Freedom, or Dr. Rose, well, that is not
what I normally mean when I use the word unexpected
in relation to a death?

5

6

A. I think there were discussions
of that sort.

7

8

Q. Do you have any recollection
of them?

9

A. Pardon?

10

11

12

Q. Do you have any recollection
of such discussions?

13

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16

A. I don't, I believe there was
contention about the definition. So that I can't
recall the exact conversations but not everybody
agreed with it until they recognized what we were
trying to do.

17

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Q. All right. Who were the five
who died before reaching the OR, please? I am now
back on page 2 of the minutes, Doctor. I am sorry,
I have jumped one, haven't I: "...deaths were
expected..." All right, you have identified those for
me.

"The remaining 15 patients though all
high risks death was not expected on



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"the ward. Five of the 15 died before
reaching the OR..."

3

4 Who were they, please?

5

6 I should say that I in review-
ing those minutes I have had trouble in identifying
7 because I don't have the detailed notes.

8

9 Q. We know that Kelly Monteith
10 was one of them because we discussed her this
11 morning.

12

13

14 A. I put Monteith in the group
15 of expected.

16

17

18 Q. Oh, yes, I am sorry. Even
19 though she had been scheduled for surgery?

20

21 A. Yes, because of extensive
22 damage.

23

24

25 Q. All right. It is one of the
five who didn't make it into the OR.

26

27

28

29

30

31 A. I have a number of six. I
32 realize that the statement says five, but as you can
33 see I have had to go back over the minutes to
34 identify them and it has been a little difficult.

35

36

37 Q. Yes.

38

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46 A. So I have now got six and nine.
47 I don't know whether that is a legitimate change, but
48 for the purposes - perhaps it might be acceptable.



J9

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Q. All right. And pre-operative deaths.

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A. The pre-operative deaths were Gage, MacDonald, Gosselin, Shrum, Bilodeau and Lutes. Now, Lutes is not on this list.

7

Q. No, he is not.

8

A. And Hodgkinson should not be

9

on this list.

Q. That is also true.

10

11

A. So what I have done in this scenario is to substitute.

12

13

14

Q. Indeed, am I not also right that Gittens did not die on the ward either, didn't he die in the ICU?

15

16

17

A. He was a ward related death because he came from the catheterization lab to the ICU.

18

Q. That is right, he went from the ward to the lab to the ICU and died there.

19

A. Yes.

20

Q. Okay, I want to be clear.

21

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A. Lutes, if I could just expand that, Lutes for some reason was missed out of the original list, we just didn't get the chart of that baby, and I don't know how we missed that, but we did.

25



J10

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2 So all that happens is Hodgkinson is excluded
3 because Hodgkinson was transferred from the Infant
4 Ward to the Operating Room and then to the ICU, so he
5 never had any contact to our knowledge with 4A/B,
6 so we place Lutes in that position then we are left
7 with the same number.

8 Q. Heyworth you have excluded,
9 he is not among the 22, not 20.

10 A. No.

11 Q. Okay, which four of those five
12 did you say would have benifitted from ventilatory
13 support?

14 A. Four of the six.

15 Q. Okay, four of the six; was it
16 four of the six, or is it now five of the six?

17 A. It is six patients who are
18 pre-operative.

19 Q. Yes. How many of those people
20 could have benefitted from ventilatory support?

21 A. I think that in reviewing
22 that I would think that most of them could.

23 THE COMMISSIONER: I'm sorry, what
24 was the question?

25 THE WITNESS: Six perhaps.

26 MR. LAMEK: Q. Well, the minutes



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record that four of the five could have benefitted from ventilatory support. I am asking you is it now four of six or is it five of six, because we now have six in that category and not five as at the time.

6

THE COMMISSIONER: Thank you.

7

8

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THE WITNESS: I think that it is, you know, in the minutes it says that two required ventilatory support, two others had respiratory arrest and one had ---

10

11

12

MR. LAMEK: Q. Am I reading a different set of minutes, Doctor? It says to me half way through the first paragraph:

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"Of the remaining 15 patients, though all high risk, death was not expected on the ward. Five of the 15 died before reaching the operating room.

Four of those five could have benefitted from ventilatory support."

19

20

A. It is just that the detail in the summary talks about the different types of respiratory difficulties that are being helped.

21

Q. Yes.

22

23

24

25

A. I would think that of the six I now have in that group, that all could have benefitted from respiratory ---



J12

This is a
very night
performance!
Does he not
value the
gravity of
this for HSC
(and for
United?)

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Q. Including the one that ---

A. Pardon?

Q. Including one who as at

January 12th you didn't think apparently could have
benefitted from it?

A. That is right. I think the
patient who is excluded in the original list was the
baby of transposition, it was Gage, and we didn't
mention respiratory support there, we just said
delay in reaching the operating room, possible
delay. So I would certainly now, because the numbers
have been changed, that might be a change, but I
would be content to say that all those six might
have been - at least six might have benefitted,
at least that should be considered.

Q. All right. Now, we have
nine postoperative?

A. Yes.

Q. And I guess we could all do
the elimination process, you have done it, could you
just give us a list of the names, please?

A. Yes. Nine postoperative
Velasquez, Hoos, McKeil.

THE COMMISSIONER: Yes, and after
McKeil?

24

25



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THE WITNESS: Lombardo, Onofre.

3

4

THE COMMISSIONER: I'm sorry, what

5

6

name was that?

THE WITNESS: Onofre, it is about

7

8

four from the bottom.

THE COMMISSIONER: Yes, thank you.

9

10

11

12

THE WITNESS: Dawson, Adamo,

Volk and Belanger.

13

14

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MR. LAMEK: Q. And in the minutes you say of those ten, and now of those nine, one is associated with medication and that I take it to be Velasquez?

19

20

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A. Yes.

Q. And five you said represented examples of failure to intervene with re-operation, four others should have been in a more intensive monitoring care situation as possible on the ward. Can you, Docotor, just identify the ones to whom you're referring in that sentence?

A. The five where there was

question of re-operation.

20

Q. Yes.

A. They are McKeil, Lombardo,

21

22

23

24

25

Onofre, Dawson. Are my numbers right now?

Q. That is four.



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Rowe
dr.ex. (Lamek)

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Then there was the question, which is Velasquez, and then there are four where the question of re-operation should have been perhaps considered and then there are four where an intermediate intensive care setting might be considered. There is Adamo, Volk, Belanger and Hoos.

MR. LAMEK: Mr. Commissioner, on the hour of one o'clock, is it time for a break?

THE COMMISSIONER: Yes. We will resume again at 2:30.

--- luncheon recess.



Rowe
dr.ex. (Lamek)

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--- on resuming.

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THE COMMISSIONER: Mr. Lamek.

4

MR. LAMEK: Thank you, sir.

5

Q. Dr. Rowe, we were dealing with
the meeting on January 12, 1981. I believe we had
come to that part of the discussion at that meeting
at which the proposal or suggestion of an inter-
mediate intensive care unit was being canvassed and
you had enumerated for me those children who fell
into the different categories described in the para-
graph at the top of page 2. I'm sorry, we were just
about to come to the intermediate intensive care unit.
Because of those fifteen for whom the category "un-
expected", as you defined it, was used, the last
sentence of the first paragraph is:

15

"Five represented examples of failure
to intervene with reoperation and four
others should have been in a more
intensive monitoring and care situation
than is possible on the Ward."

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And you had identified those four as being Hoos,
Adamo, Volk and Belander, I think, and that was the
point we had come to.

THE COMMISSIONER: No, not yet, at
least not in my notes.



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dr.ex. (Lamek)

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MR. LAMEK: Oh, I've got Belanger on
my notes "with greater care".

4

THE COMMISSIONER: No, no. The four
should have been in more intensive monitoring and care
were who?

6

MR. LAMEK: I thought they were.

7

Q. Perhaps you can tell us again,
Doctor.

9

A. I believe they were Adamo.

10

Q. Yes.

11

A. Volk.

12

Q. Yes.

13

A. Belanger.

14

Q. Yes.

15

A. Hoos.

16

Q. That's what I thought I said a
moment ago.

17

MR. ORTVED: You did.

18

MR. LAMEK: But not in that order - I
had them as Hoos, Adamo, Volk and Belanger, and it
was thought that those four perhaps should have been
in a more intensive monitoring and care situation
than is possible on the Ward.

22

23

Q. Are you able to tell me, Doctor,
what degree of monitoring and care you thought they

24

25



Rowe
dr.ex. (Lamek)

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AA3 2 should have been receiving? I guess what I'm asking
3 is, how high is up!

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9 A. I think that all those four we
considered were particularly susceptible to changes
that might tip the balance in the sense that Volk
had a lung problem as well, Hoos had a chylothorax,
which is a collection of fluid in the chest, and
Adamo perhaps could have benefitted from a stay for
a longer period in the intensive care.

10 Q. I think, Doctor, you told me
11 why you thought those patients were candidates for
12 a higher level of care.

13 A. Yes.

14 Q. But I think my question was, how
15 much higher than they were able to receive on the Ward?

16 A. Somewhere between the Ward and
the Intensive Care.

17 Q. Somewhere in that area?

18 A. Somewhere in between the Ward
19 and the intensive care level.

20 Q. In considering that as perhaps
21 something that would have helped those children, did
22 you notice in looking at the charts whether constant
23 nursing care had been ordered for any of them?

24 A. No, I don't believe I did.

25

Ross's thesis was that a higher level of care was required than could be given on the ward, - i - need intermediate care. But he didn't know and didn't check whether any enhanced level of nursing care had been ordered on the ward! If he didn't know how much care these patients were receiving, how could he say they needed more?

Reasonable to believe that if Dr X thought a patient need enhanced care he would have ordered it and, in the climate which prevailed, would have raised hell if told the enhanced care was not available.

Why not the Head Nurse give Ross a fight on the intermediate care issue. Any thing that might get dying patients off the ward and reduce the tension and poor morale of the floor nurses would of course have their support.



Rowe
dr.ex. (Lamek)

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AA4

2 Q. Would that not have been an
3 important consideration in deciding whether greater
4 care than is available on the Ward was appropriate?

5

A. I don't have the same confidence
6 that you have in the notations necessarily on that
7 point. But I think that if there had been any issue
8 in that regard at this conference, that would have
been addressed by the nursing group.

9

Q. I'm not sure I understand that.
10 But let me ask the second half of the question.

11

Was there any notation that you saw
12 on any of the records of these four children to
13 suggest that an enhanced level of care had been ordered
14 for them?

15

A. I'm not sure of it because I'm
not sure whether there were notes on those charts at all
16 because that point was not specifically examined by me.

17

THE COMMISSIONER: I'm sorry, what was
18 that you said?

19

THE WITNESS: I'm not sure whether
there were notes to that effect or not on those charts
20 because that point was not specifically addressed by
21 me.

22

THE COMMISSIONER: But I thought you
23 said something about it would not have been appropriate,

24

25



Rowe
dr.ex. (Lamek)

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2 or it would have been appropriate. Did you say
3 anything about that?

4

THE WITNESS: No, I don't think so.

5

MR. LAMEK: I didn't hear Dr. Rowe
6 say that.

7

THE COMMISSIONER: No, but I thought
8 you may have said something -- I am just really, I
9 guess, following up Mr. Lamek's question. Would it
10 have been appropriate to have ordered constant nursing
11 care or shared care or anything of that sort?

12

THE WITNESS: Yes, yes, that would have
13 been, for most of those patients.

14

MR. LAMEK: Q. I guess my concern
15 is this, Dr. Rowe, if it was your opinion that those
16 four children should have been receiving a higher
17 level of care and monitoring than is normally available
18 on the Ward, would it not be relevant to know whether
19 they were at least being provided the highest level
20 of care that the Ward could afford to them?

21

A. Yes.

22

Q. That is to say constant care?

23

A. If that was available.

24

Q. Well, did you make any enquiry
25 as to whether it was available?

26

A. I don't recall doing so.

27



Rowe
dr.ex. (Lamek)

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Q. Did you make any enquiries as
to whether it was requested?

A. No, I don't remember doing so.

I would remind you, however, that this conference was
a provocative type of conference in which we were
proposing far to one side what we thought might be
the appropriate thing to do, to test to see what
people thought about that suggestion.

Q. Well, I take it, Doctor, that
the idea of an intermediate intensive care unit is,
forgive me, I don't mean to be offensive, a little
like motherhood - it is hard to oppose it in concept,
isn't it?

A. Well, I think the nurses might
have had very significant reservations about it.

Q. Well, they didn't express them
in any event, you are saying?

A. Not at this conference, no.

Q. All right.

And as I understand you, just so I am
clear, while saying that these four children should
have been in a more intensive monitoring and care
situation than is possible on the Ward, you had not
made an enquiry and, to your recollection, didn't have
any information as to whether the highest level of

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25



Rowe
dr.ex. (Lamek)

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AA7 2 care that might be available on the Ward had been
3 ordered for them?

4 A. Right.

5 Q. Well, does it come to this,
6 Dr. Rowe, that all of the deaths which you classified
7 as "unexpected", by your definition, all but one; that
8 of Velasquez, at the end of this meeting, appears to
9 have been explained by the conclusion that if only
10 the surgeons had moved faster to reoperate and if
11 only a higher level of care and monitoring were
12 available, those children might not have died.

13 That's a rather terse way of putting
14 it but it is it an unfair way of putting it?

15 A. I think it is unfair.

16 Q. Well, you tell me then on what
17 basis, if at all, you were able to resolve the
18 unexpected nature of those deaths?

19 A. Well, I think what we were doing,
20 as I have said before, in order to go as far as we
21 possibly could to examine whether any management
22 change in these babies might have produced any
23 difference, we put the provocative proposal that some
24 babies should have gone back to surgery earlier. If
25 we get eventually to some of these babies, as I
presume we will --



Rowe
dr.ex. (Lamek)

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Q. Yes.

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A. -- then it will become evident that in some situations where theoretically a return to the operation room might have been desirable, the practical severity of the malformation was such that that might not have done the job.

7

8

Q. It might not have made any difference.

9

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A. And it was in that sense that this examination was made. I think it would be totally unfair to the parents of those children or to the surgeons to suggest that there was a frank failure to reoperate when the conditions were not loud and clear.

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Q. Believe me, I didn't mean to create that impression as being the outcome of the meeting. Forgive me if I did.

But you had fifteen deaths which you classified as unexpected in the sense that -- well, what was the definition again - they warranted further review, and they had died on the Ward. Would some intervention have made a difference?

A. Yes.

Q. And you were able to suggest *way* at the end of the meeting, were you not, that in one *L*



Rowe
dr.ex. (Lamek)

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AA9 2 or another if facilities were available and so on,
3 perhaps some intervention might have made a difference.

4 A. I think that was the conclusion.

5 Q. Okay. And that's a fairer way
6 of putting it, I acknowledge.

7 A. I think so.

8 Q. And the meeting then it seems
9 got into a discussion of the ICU, the proposed
10 intermediate ICU, and perhaps more cardiovascular
11 surgeons doing perhaps more aggressive reoperations
12 and so on. But there were questions about a few
13 things that, from my reading of these minutes, do
14 not appear to have been said or raised, Doctor. Per-
15 haps you can help me.

16 Did you or did anyone else at this
17 meeting say expressly that the increase in ward
18 deaths was attributable to a higher incidence of
19 very serious cardiac problems? Was that advanced
20 as an explanation?

21 A. I think that may have been. I
22 don't recall. I haven't made a note to that effect
23 and I don't recall.

24 Q. Now that was in fact, if I under-
25 stood your evidence this morning correctly, the view
to which you still tended to subscribe, wasn't it?



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dr.ex. (Lamek)

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AA10

A. Yes, I would assume we hadn't incorporated that here because everybody was agreeing with that situation and we went into the conference with that, without any disagreement about that issue.

5

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7

8

Q. Doctor, you are suggesting to me that the things that you unanimously agreed upon don't appear in the minutes, or are you suggesting that that was too obvious to bother stating?

9

A. Yes.

10

11

Q. Everybody started with that as a premise?

12

A. That's right. That is my understanding of that.

13

14

15

Q. And you recall, therefore, no discussion on that point? It wasn't worth discussing; everybody agreed on that?

16

A. Yes.

17

18

19

Q. Did anybody remark on the fact that a substantial number of these Ward deaths had occurred in the early hours of the morning?

20

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22

A. I don't recall that, but I am quite sure it must have been mentioned. But I don't recall that there was a major issue about that either.

23

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25

Q. Forgive me, Doctor, I don't mean to be facetious or contentious but what does appear in



1

AAll 2 the minutes?

3 A. Most of the important things
4 that we discussed and agreed upon.

5 Q. But you are sure there must have
6 been some discussion of the question of the timing
7 of these deaths but there is no reference to that in
these minutes?

8 A. No.

9 Q. I take it from the follow-up
10 comment that you made, that if that comment was
11 made or if there was any discussion, it was not
12 regarded as an important observation?

13 A. Or that it wasn't disputed in
14 any way or that people didn't think it was of the
greatest order of importance.

15 Q. All right.

16 Did anybody at the meeting say that
17 there was a shortage of nursing on the night shift
18 on Wards 4A and 4B?

19 A. I don't know whether anybody did
20 or not. I don't recall.

21 Q. Did anybody say, Doctor, the
22 establishment of an intermediate intensive care unit
23 is great but it's a long way down the road, what are
24 we going to do now to stop this run of deaths? Did

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anybody say that?

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A. No.

3

Q. Was there no concern expressed
at the meeting to try to find an immediate explanation
and solution to what was, as of the end of December,
an immediate problem with five deaths in that month?

4

A. Yes.

5

Q. Was there discussion to that

6

effect?

7

A. No. I think that we were trying
to look at the whole six-month period and we were not
looking at that particular moment at the last five
cases.

8

Q. Well, did anybody say, well,
what's going to happen for the next six months until
we get the intermediate ICU? Are these deaths going
to continue, Dr. Rowe? Did anybody ask that question?

9

A. I don't believe anybody did.

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Q. Did it occur to you to ask
that question to yourself?

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A. No. I don't believe at the
time. I think that at the time we felt that if we
could get on with this unit we probably would
resolve the issue. At least we might resolve the
issue. I don't think we were sure about that because
we recognized that this was a large number of infants
who were seriously ill but we hoped that it might
improve the situation.

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Q. Doctor, if the proposal for
an intermediate intensive care unit were to go forward,
what was your expectation as to when that proposal
might be implemented?

11

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A. I thought within a couple of
months. Two or three months; maybe earlier.

15

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18

Q. Well, it was agreed by the
people at the meeting the next step would be to form
a small subcommittee headed by Dr. Fowler:

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" ... which would include the head
nurses of the cardiac ward, cardiac
surgeons and a representative of the
physicians in ICU so that decisions can
be made concerning the size of such
an intermediate intensive care unit,



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2 "where it should be sited, how many
3 extra staff would be necessary and
4 what equipment items would be
5 required. ... their conclusions would
6 serve as the basis for an application
7 by Drs. Trusler and Rowe to the
8 Program Advisory Committee if
9 necessary."

10 What is the jurisdiction of the
11 Program Advisory Committee?

12 A. Well, that committee assigns
13 priorities and considers the validity of the requests
14 for a new program.

15 Q. Did the recommendation - I am
16 sorry?

17 A. Which this would constitute.

18 Q. Did the matter proceed as
19 recommended at the foot of page 3 of the minutes?
20 Was a small subcommittee formed?

21 A. Yes, it was.

22 Q. And did it consider the
23 matters that were assigned to it?

24 A. Yes, it did.

25 Q. And on the basis of their
conclusions was an application made by yourself and



Rowe, dr.ex.
(Lamek)

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Q. Did you have an impression or
a perception as the months went by from July through
to December that the incidence of severe illness
was continuing at the same level that you had observed
in July and August?

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A. No, I think it fluctuated
somewhat, but there was still an ongoing large number
of babies, but I think the clustering was most marked
in July and August, and then started - fell right off
in November but started off again in December.

Q. Which happens to be the month
in which the five mortalities occurred?

A. Yes.

Q. Which I take it are indicative
of the seriousness of the illness of the patients?

A. That is what we believe.

Q. Other than your observation
that the mortality rate seems to have declined in
November when, as I understand it, you were away,
do you have any information as to the severity of
illness of patients who were admitted in November?

A. No, I don't have that
information.

Q. And therefore to the extent
you believe there was a fluctuation and November was



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a month in which less seriously ill patients were coming in, that is a reflection of the fact that in November there was only one mortality on the ward?

A. I would make that assumption.

Q. Is that not an entirely

circular argument? ~~The~~ deaths are high because the patients are seriously ill; how do you know they are seriously ill? Because their deaths are high?

A. I can only tell you that I get the reflection of those fluctuations from the staff who were involved and the ward chiefs.

Q. Yes.

A. I think if you wish to question on those items month by month you would have to speak to the ward chief of the month.

Q. Right. I shall have to do that, Doctor, thank you.

Can we go now to the babies who had died and who were reviewed and categorized for the purpose of the meeting on January 12th? We have covered some of them, of course, and I don't intend to go over them again, and I think we resolved the differences between your list and mine, Dr. Rowe.

I had wondered why Laurette Heyworth and Paul Murphy and Matthew Lutes were not on. I



BB.6

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2 know now why the first two were not on and Lutes
3 should have been, as I understand it.

4 And on the other hand my list does
5 not include Hodgkinson and Gittens because my list
6 comprises those who died on the ward and those two
7 did not.

8 Now we have already discussed
9 Bilodeau, Turner, Taylor, Shrum, Velasquez and
10 Monteith in the context of the September conferences,
11 and other than the classification of Bilodeau - and
12 was it Shrum too? - as unexpected by the definition
13 that you adopted --

14 A. Yes.

15 Q. Other than that --

16 MR. SCOTT: Mr. Commissioner, I
17 wonder if I could just interrupt?

18 THE COMMISSIONER: Yes, Mr. Scott?

19 MR. SCOTT: This is going to be a
20 very long examination in chief. Indeed for a moment
21 I thought we were in cross-examination, but it is
22 going to be a long examination and it may take some
23 time.

24 At the stage that just ended Mr.
25 Lamek had gone through a series of questions in which
he asked the Doctor about things that he did in the



Rowe, dr.ex.
(Lamek)

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2 months running from September through to December.

3 It seems to me fair at this stage
4 we should not have to wait until the end of the case.
5 It seems to me fair at this stage that if Mr. Lamek
6 thinks there is something that the Doctor should
7 have done at that time, it seems to me fair to the
8 Hospital that I represent that that should be put to
9 Dr. Rowe now so that he can comment on it.

10 THE COMMISSIONER: I thought he had
11 done that. Perhaps he hasn't.

12 MR. SCOTT: No.

13 THE COMMISSIONER: Have you anything
14 further that you want to --

15 MR. SCOTT: What does Mr. Lamek think
16 should have been done? He is making criticism, as
17 I understand - very gentlemanly and in polite fashion
18 he is making - he is presenting questions that
19 suggest obliquely that the determinations made and
20 the course of conduct followed up to December were
21 not adequate. What were you going to do for the next
22 16 months? Just wait until you had more deaths?

23 Now I don't object to those questions,
24 but it seems to me in fairness that if Commission
25 Counsel has something that he thinks should have been
done this doctor in the witness box should be allowed



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2 to hear what that is and be allowed if he wants to
3 make a comment about it.

4

5 Now I don't act for Dr. Rowe so this
6 interjection is made on behalf of the Hospital. What
7 has happened is we have now gone off this exchange
8 and whatever Mr. Lamek thinks should have been done
9 has not been put to the Doctor.

10

11 THE COMMISSIONER: Well, can I just
12 make a guess that what he has in mind that perhaps
13 he is suggesting that Dr. Rowe should have done what
14 we are doing now: try to find out the cause of death
15 of these children.

16

MR. SCOTT: Well --

17

18 THE COMMISSIONER: That there may
19 have been something else that could have been done.

20

21 MR. SCOTT: Well, obviously I accept
22 that and I think that the evidence reveals that the
23 Hospital and the doctors and staff were concerned
24 about that and were doing certain things. Is there
25 something else that Mr. Lamek says he should have
done in December? If there isn't, fine, but if there
is I think fairness requires that we know what it is.

26

27

28 THE COMMISSIONER: Well, I will let
29 you answer that if you want to, Mr. Lamek.

30

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32 MR. LAMEK: Mr. Commissioner, only

33

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BB. 9

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2 to this extent! I hope Mr. Scott knows me well
3 enough that he would not think I would be deliberately
4 unfair.

5 MR. SCOTT: Oh, no.

6 MR. LAMEK: I know that. In the
7 course of some of the questions I have I hope
8 suggested to Dr. Rowe things that he might have done.

9 I suggested, for example, that some
10 attention to the questioning of the timing of deaths
11 might have been appropriate, but I have heard from
12 Dr. Rowe that that was not a thing that they
13 addressed.

14 Beyond that I have nothing specific
15 by way of a panacea to questions that might have been
16 arising at the time. If I had I would put it to
17 Dr. Rowe.

18 I am concerned to know what he was
19 thinking about and equally what he was not thinking
20 about and that is the thrust of the examination as
21 far as I am concerned.

22 MR. SCOTT: I am quite satisfied
23 if my friend wants to ask the Doctor did you think
24 about this, did you think about that? I have no
25 quarrel with any of those questions, but I rather got
the implication that my friend was saying I know



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2 something that I think you should have done in
3 December.

4 We are all second guessing to a
5 certain extent, and I now have his assurance that
6 he has no suggestion to make as to what should have
7 been done in December except to review the history
8 of the deaths, and I am content.

9 THE COMMISSIONER: Well, Mr. Scott
10 is happy.

11 MR. LAMEK: If Mr. Scott is happy
12 then I am happy, Mr. Commissioner.

13 MR. SCOTT: As long as we have that
14 rule established.

15 MR. LAMEK: Then happiness may not
16 be that important to me.

17 Q. We have already talked about
18 Bilodeau, Turner, Taylor, Shrum, Velasquez and
19 Monteith. In the course of preparing for the meeting
20 of January 12, 1981, Dr. Rowe, had your views as
21 you have given them to us in the course of yesterday
22 and this morning, had your views on any of those six
23 deaths changed in any way between the end of September
24 and the middle of January?

25 Q. My views on the --

Q. On the six whose deaths we
have already canvassed here in this hearing?



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2 A. No.

3

Q. Thank you. Then taking the
4 children in chronological order, let's look next to
5 the case of Alan Perreault.

6

Once again we have behind you and
7 to your right a diagram purporting to represent the
8 stucture of the heart of this child.

9

In your review of the chart does
10 that accurately depict the state of Perreault's heart?

11

A. Yes.

12

MR. LAMEK: May that be the next
13 exhibit, Mr. Commissioner, please?

14

THE COMMISSIONER: 66.

15

--- EXHIBIT NO. 66: Heart diagram of
16 Alan Perreault.

17

MR. LAMEK: Q. Could you please,
18 Doctor, describe the defects and anomalies that appear
19 in the heart of this child?

20

A. Yes. This boy had the most
extreme form anatomically speaking of hypoplastic
left heart syndrome. That is a spectrum of several
anatomic abnormalities on the left side of the heart.

21

The right side is rather much the
same as in a normal situation except that it is
enlarged considerably as a consequence of the disease
on the other side.

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But if we specifically look at the left side of the heart there is an extremely small chamber to the left ventricle as contrasted with the normal over here (indicating). The mitral valve is what is known as atretic.

Q. I am sorry, Doctor?

A. Atretic being it is not patent at all. It is really absent.

There is a valvular structure there but it is completely sealed. There is no exit from the left atrium above into the pumping chamber below. So mitral atresia is the term given to this association.

In the aorta, the aortic valve is also atretic, so that in fact there is no entrance into the pumping chamber and there is no exit from the pumping chamber.

Consequently for a baby to survive there has to be some way in which the blood which is being pumped out to the lungs can return to the left side of the heart and then get somehow or other out into the circulation.

Since it cannot go down here and cannot go out there, it has to go somewhere else to mix with the other side, and it is usually possible through a foramen ovale or small communication in the



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(Lamek)

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2 atrial septum or wall between the two atria here,
3 there is a small aperture like a trapdoor called
4 a foramen ovale.

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That is a mechanism by which blood can get to the left side of the heart during the fetal existence of the baby, but after birth that tends to stay over. About a quarter of the population has a permanent trapdoor there, but it does not result in any abnormality because it is kept shut by the pressure relationships.

In these babies that is necessary for survival usually. So that blood can then go across through this left side of the heart to the right ateria, through this trap door, which it mixes again with blood from the vena cava. So you have got again the Waring blender issue of a mix in the right atrium. Blood will then go down into the right ventricular which is therefore receiving much more blood than it would ordinarily do, and therefore enlarges, and blood goes out into the pulmonary artery which also enlarges, and the ductus arteriosis which is up here remains open. Then blood that goes through the ductus arteriosis, blood will go through in this direction and perfuse the body through the aorta and go backwards around here right down to the coronary arteries. But this structure is very, very small, it is about two to three millimetres in diameter in this situation as opposed to something



Rowe, dr.ex.
(Lamek)

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about three times that size normally.

3

4 It therefore becomes clear that what
5 really determines how well a baby with this situation
6 might do, is how long this structure, the ductus
7 arteriosus, which is a very unreliable vessel,
8 remains open. The moment it starts to close there is
9 no way in which blood can perfuse the essential
10 organs of the body. So there is a situation of
11 rapid deterioration and death.

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This particular baby at autopsy had
no communication between the two top chambers. We
can only assume that that communication was sealed
during the course of its life after birth, at a later
stage. That is why I categorize it as perhaps the
most severe case because the only other way blood
can communicate with this side would be through a
little hole in the coronary sinus that I talked about
with one of the other babies, that circles around
the back of the heart and drains into the side, or
through vessels in the lung. The usual and expected
age of death in this sort of baby, who really dies as
this thing shuts off, is about four and a half days.
That is, some babies at one or two days, some babies
die at six or seven days and only exceptional babies
live much longer than the week.



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The unusual thing about Alan Perreault predicted that he would be dying and after a diagnosis was made and he considerable period of time. But xing when we make this diagnosis in today the patient is transferred back laboratory, because there is no intervention for this type of child that in our institution.

It is really in the realm of inoperable or possibly heroic surgery, if one were to try anything. A number of attempts have been designed to do this but so far there haven't been any with convincingly good results. So it is regarded as a situation where death is inevitable.

16 Q. Doctor, thank you. Clearly
17 from what you have said there was nothing that your
18 Division or the Cardiovascular people could do for
19 Alan Perreault. He was admitted on June the 25th
I think and when he died he was 27 days old.

20 It appears from everything that you have
21 said that what was unexpected in any sense of the
22 word about Perreault was not that he died but that
he survived so long, is that right?

A. Yes, that is the situation.



Rowe, dr.ex.
(Lamek)

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When I referred the other day to the fact that we were worried about his survival, of course I meant that there was a little concern that the longer he went on that perhaps there had been a serious error of diagnosis.

7

8

Q. Now, Doctor, it appears from the chart, and I think indeed your note at page 50 of the chart.

9

A. I am sorry ---

10

11

12

Q. Have you found that yet, I think that is your signature against the order of June 25th, the date of admission.

13

A. Page?

14

Q. 50.

15

A. That seems to be the one page that is missing in my book.

16

17

Q. It is on the back of the other page, yes, there it is.

18

A. I am sorry.

19

20

Q. I think that is your signature, is it not there on the right hand side.

21

A. That is a confirming signature.

22

23

Q. Yes. The order is: "Do not resuscitate", and I take it that order was written after consultation with the consent of the parents?

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A. Yes.

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Q. And it had been decided again
in consultation with the consent of the parents
to provide no active treatment for this baby, had it
not?

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A. Just supportive.

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Q. Just supportive and keep him
comfortable?

5

A. Yes.

6

Q. But when in fact Alan

7 Perreault survived beyond a week and into the early
8 days of July you have said, the case was reassessed,
9 wasn't it?

10

A. Yes, it was.

11

Q. Because since he was not
12 expected to live so long, as you have said, you have
13 to wonder whether the diagnosis could have been right.
14 At page 30 -- I am sorry, the reassessment notice
15 at page 45 of the chart I think.

16

A. Yes.

17

Q. And that I believe to be your
18 note as well, Doctor?

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A. It is.

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Q. And in it you record as I
21 read your handwriting at the bottom:

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"Impression. I do not doubt the original diagnosis is correct. I see no grounds to suggest improvement has occurred - the signs indicate slow deterioration. Whether anatomic variants are responsible for the unusually long survival (at present 20 days) is debatable but there are no unusual features except that the left ventricle may be slightly larger than average size in one echo mode."

A. Yes.

Q. "My own view would be not to study further or intervene at this point."

In other words, having made the reassessment you were satisfied with the validity of the diagnosis. Although it was a matter of I take it some wonderment that the child had survived as long as he had there really didn't seem any basis to consider doing anything other than what had already been done.

A. Yes.

Q. There is one thought however, in the final paragraph of your reassessment report.



Rowe, dr.ex.
(Lamek)

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You say:

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An eventuality, I take it that you thought to be
highly unlikely.

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A. Yes.

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Q. "If that were decided
hematologic study and probably
cath/angio would be indicated and
diuretic started."

I plan to consult with Drs. Izukawa,
Freedom and Trusler on that issue,
and discuss the situation further with
his parents."

20

21

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And indeed you did discuss the
situation with the parents, did you not, Doctor,
and they said they would get back to you, they would
think about it and decide what they wanted to do.
And events eventually overtook them and on the day



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that they were to get back to you in fact the child
died, did he not?

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A. Yes.

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The child died on July 8th
in the early afternoon. Could we turn to the
Progress Notes, the nursing notes for that child,
page 43 of the chart. The notes appears to be that
of Miss Morin and (later Mrs. Trajner) dated June
8th, 1980 covering the period from 7:30 a.m. to
1:45 p.m.:

"Feeding baby at 12:30. Baby did not
void all day. Remained very tachypnic
and air hungry but sucking eagerly on
bottle. Approximately around 3:15
baby began to Cheyne-Stoke."

That is the breathing associated with
dying, isn't it, Doctor?

A. Yes.

Q. "Colour became quite pale and
slightly cyanosed but no improvement
noted with oxygen. Dr. Contraras
notified. No breath sounds heard.

ECG monitor showing occasional
ventricular activity. At 13:45 baby
had absent respirations and absent apex.



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"Dr. Contraras called again and baby
was pronounced dead."

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So Baby Perreault died on August the
8th. He seems to have died very quietly, Doctor.
The notes suggests that almost, and I don't want to
sound maudlin about this, but just drifted away as it
were, that is the picture that is painted by the
note, isn't it?

5

A. Yes.

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Q. Doctor, I have to put to you
that that death is in very sharp contrast to the
sequences that we were referring repeatedly yesterday,
was it not?

A. Yes.

Q. Now, here was a baby who was
certainly very seriously sick, and inevitably would
die as you have said. I asked you yesterday whether
the pattern of terminal events that we were seeing
was common, and I don't suggest for a moment that
one can base anything upon this one child, but
nevertheless here is one baby who certainly fits the
bill of a very, very sick child. The manner of his death
was entirely, entirely different from anything that
we have looked at so far. Is that a matter of any
significance in the exercise on which we are engaged,
Doctor?



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A. No, I don't believe so. He had been in - despite the suggestion that he had been stable, he had been in chronic congestive failure. The huge surprise of course had been that he hadn't died before.

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Q. Yes.

7

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A. That he had signs of gallop rhythm and bad congestive failure, his liver was 6 centimetres below the custom margin so he was obviously getting worse.

11

Q. Yes.

12

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A. Getting worse over time, so his condition was really not stable. I think if you compare the notes from the 5th of July to the 7th and they are written by a cardiologist, the notes I am referring to, there is a change.

16

17

18

Q. I don't suggest he was stable, Doctor, indeed the pattern is one of slow and steady decline.

19

A. Deterioration.

20

Q. Until fatal entirely?

21

A. Yes.

22

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Q. In very sharp contrast to what we were seeing yesterday. That is quite often a pattern of stability and then a very sudden and



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rapid decline with dramatic terminal event?

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A. Yes.

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Q. Were the circumstances of
Alan Perreault's death consistent, in your view,
with anything other than death that you expected
in light of his anatomical condition?

6

7

A. I think they are quite
compatible with his anatomical condition.

8

Q. Are they consistent with any-
thing else, that pattern of death?

9

10

11

A. His heart rate here, I don't
see notes on it.

12

13

Q. No suggestion of arrhythmia
there, is there?

14

15

A. No.

16

Q. Or seizure activity?

17

18

A. No. He was having occasional
ventricular activity which means his heart rate must
have slowed.

19

20

Q. Yes.

21

22

A. So that his heart rate slowed
before he died.

23

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Q. Yes.

25

A. I don't see a note saying
when that happened but I presume, I am trying to see



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the record on this chart where the nurse decided
that Dr. Contraras should be called, as compared to
where the baby was at some notated time before that.

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The record is a little cut off on one margin on my copy. Approximately around (something) the baby began to change Stokes but prior to that had been sucking eagerly on the bottle. So that presumably something happened at that time and from that time to death was - I can't tell from this - half an hour.

8

Q. Half an hour.

9

10

11

A. So that the deterioration appeared there to be rapid. The sudden change in the condition appeared to be rapid.

12

13

14

Q. Well, I suggest to you, Doctor, that this is not the suddenness of change that we were seeing yesterday. It is not the dramatic change that we were seeing yesterday, is it?

15

A. Well, it is certainly sudden.

16

17

18

Q. You mean from the time he begins to do that characteristic breathing, Cheyne Stokes; it is a mere half hour later that he's dead?

19

A. Yes.

20

21

22

23

Q. But in the meantime he's not going through various arrhythmias, is he, and he's not having seizure activity and he's not doing any of the things we've seen yesterday. He wasn't vomiting.

24

25



Rowe
dr.ex. (Lamek)

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DD2

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A. I don't know what the nurse means by "ECG monitor having occasional ventricular activity, but I assume that that could mean either that there was no heartbeat except for occasional beats or that there was occasional ectopic activity.

3

Q. Yes.

4

A. Irregularity.

5

Q. Yes.

6

A. I think if there was no heartbeat except for occasional ones, that would have been a cause for getting someone in to collaborate with the nurse.

7

Q. Except the orderlies do not resuscitate on this?

8

A. No, I didn't mean to resuscitate; I just mean to confirm that that was happening.

9

Q. Well, perhaps we can clarify that later if we hear from Miss Nelles.

10

Doctor, can we have a look at the chart of Amber Dawson.

11

MR. STRATHY: Is that to be marked as an exhibit, the last one?

12

THE COMMISSIONER: The word "chart" is going to give us some trouble. I prefer "diagram" for this and "medical records" for the other. So, we

13

14

15



Rowe
dr.ex. (Lamek)

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DD3 2 don't use "chart", or we will be at cross-purposes.

3 So, you are referring to the medical
4 records then of Dawson?

5 MR. LAMEK: Yes, please.

6 THE COMMISSIONER: Exhibit 59.

7 MR. LAMEK: Yes, please, and the Dawson
diagram.

8 MR. SHANAHAN: Mr. Chairman, if I might
9 interrupt for a moment. It is probably an appropriate
10 time. It is an issue that I was going to address
11 today in any event.

12 THE COMMISSIONER: Yes.

13 MR. SHANAHAN: I was contacted late
14 yesterday by the family of the Dawson infant, by
15 Heather Dawson, her mother, and asked at this late
16 date to put to the Commission her desire that their
family have standing here in the Commission.

17 I believe that some time ago they
18 had received the Commission correspondence that was
19 addressed to all parents, but for reasons best known
20 to themselves have decided at this moment to act and
21 they request that we put to you their desire, as I
22 said, to have standing here along with the other
23 parents and that, if that standing is granted to them,
their interests be represented by myself throughout

24

25



1
DD4

2 the Inquiry.

3 And as we head into the Dawson child,
4 I had intended to address the issue later as we
5 closed the day but, with us heading into it now, it's
6 as good a time as any to bring that up.

7 THE COMMISSIONER: Yes. Well, there
8 is no problem about it, Mr. Shanahan. Any parent
9 is entitled to have standing and if their standing is
through you, that is, of course, quite satisfactory.

10 MR. SHANAHAN: Thank you.

11 MR. LAMEK: Mr. Commissioner, I'm in
12 your hands. It is 3:30 and I think it likely that
13 I can get through the Amber Dawson file in the next
14 little while. Maybe you would prefer to go straight
15 through without a break in the hopes of ending a little
earlier today, but it is entirely up to you, sir.

16 If you propose to take a break, this
17 might be a convenient time to do it, before we start
18 the Dawson child.

19 THE COMMISSIONER: Well, how long, if
20 you went -- how long would the Dawson matter be, do
21 you anticipate? About half an hour?

22 MR. LAMEK: Probably not more than
that.

23 THE COMMISSIONER: Well, could I have a

24
25



1

DD5 2 show of hands whether we have a break or not.

3 Those in favour of a break, please?

4 Those opposed?

5 Break it is then. We will take
ten minutes.

6 MR. LAMEK: What could be fairer than
7 that.

8 --- short recess.

9 --- on resuming.

10 THE COMMISSIONER: Yes, Mr. Lamek.

11 MR. LAMEK: Thank you, sir.

12 Q. Doctor, we're moving on to the
13 case of Amber Dawson, who died I believe on July 28,
14 1980 at eleven months of age.

15 Amber Dawson, am I right, Doctor, was
16 no stranger to the Hospital For Sick Children, she
17 had undergone surgery at the Hospital at the age of
one month, did she not?

18 A. Yes, she had.

19 Q. And at nine months she had been
20 readmitted for further surgery.

21 A. Yes.

22 Q. And then on July 23, 1980, at
23 the age of eleven months, she came back into the
Hospital For Sick Children.

24

25



Rowe
dr.ex. (Lamek)

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DD6

2

A. Yes, she did.

3

Q. And, indeed, the size of the
chart or record that we have for her reflects the
fact that there were three admissions?

5

A. It does. . .

6

Q. Yes.

7

Now, again behind you and to your
right, Doctor, there is a diagram of what purports
to be the heart of Amber Dawson. Do you so recognize
it from your knowledge of this file?

11

A. I do.

12

MR. LAMEK: May that be the next
exhibit, Mr. Commissioner, please.

13

THE COMMISSIONER: Yes. Exhibit 67.

14

--- EXHIBIT NO. 67: Diagram, Amber Dawson.

15

16

17

18

MR. LAMEK: Q. And could you,

Doctor, again describe the cardiac problems of this
child and, if you can, at the same time the nature and
results of the two earlier operations.

19

20

21

Doctor, I have been asked to make this
request of you, please - people are anxious to make
a note of your description of the heart - could you
perhaps take it a little more slowly.

22

A. I'll try.

23

Q. Thank you.

24

25



Rowe
dr.ex. (Lamek)

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DD7

2 A. This diagram is a little different
3 from others because it represents the state at the
4 time of the last admission. But I can tell you that
5 in the initial stages, the defects were principally
6 those of communication between both the pumping
7 chambers and the receiving chambers, the ventricles
8 and the atria.

9 So, there was a defect or a hole at
10 the atrial septal level, a hole allowing blood to
11 pass from the left atrium to the right.

12 At the lower level between the pumping
13 chambers there were several holes and at least three,
14 I believe, required repair, and these were of various
15 sizes and existed prior to their repair so that
16 blood could go from the left side to the right.

17 All the other structures in the heart
18 appeared to be normal as far as I can recall.

19 So, the problem was simply that of a
20 large defect here and a series of defects below,
21 all of which tended to result in blood pouring through
22 from the left side of the heart to the right.

23 So that at this level of the heart, the
24 atrial level, there was a mixing with the oxygenated
25 blood from the left side, and this went down into
the right ventricle where it received more additions



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DD8

2 of highly oxygenated blood and a huge amount, there-
3 fore, of blood flowed out to the lungs where it was
4 distributed and came back again fully oxygenated.
5 Some of it would go through again here (indicating);
6 the rest of it would go down here and another increment
7 would go across at ventricular level and, then, what
was left would go out into the aorta.

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9
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12

Now, this was a fairly massive amount
of what is called left-to-right shunting, and that
led to the appearance of this baby at about three
weeks of age in this institution, I think, and at
that time the baby was in congestive heart failure.

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The other thing that is of importance
in this baby was that this baby was small for gesta-
tional age - that means that she was underweight for
the length of time she had been in the womb - and she
weighed only 1,800 grams when she was born. So, she
was a small baby and that made this whole proposition
that more serious. It would be serious in anybody
but, with a very small baby, especially gestational
age baby, which is at high risk for a number of
problems, this was important.

22
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So, it was not surprising there was
heart failure early on.

To cope with that, what was done was to



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DD9 2 place a band around the pulmonary artery, again, just
3 like a piece of string that was tied moderately
4 tightly. The purpose of that was to raise the
5 resistance in this vessel, which, you remember, leads
6 out to the sponge, which is the lung, to raise the
7 resistance in this vessel to such a degree that it
8 would prevent this waterfall that was going on from
9 the left side to the right at both levels.

10 So, that operation was the first opera-
11 tion and, unfortunately, that didn't do as much good
12 as one might have hoped and the degree of heart
13 failure progressed to the point where, within a very
14 short time, it became obvious that unless this could
15 be repaired, the baby would not survive. So that a
16 repair was performed by Dr. Trusler, I think, but I'm
17 not absolutely sure of the surgeon's name.

18 Q. Yes, it was Dr. Trusler.

19 A. Yes.

20 And these defects were closed with
21 patches. This defect was closed with a patch and
22 the constricting band in the pulmonary artery, which
23 is applied, of course, on the outside of that artery,
24 was released and the constriction which remained was
25 dilated with suitable instruments so that the size of
the artery was restored to, if not the same as it had



Rowe
dr.ex. (Lamek)

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DD10

2 been before, at least very close to it. The baby
3 was then returned after that operation to the
4 Intensive Care area.

5 The only other point I want to make
6 with this diagram is what is implied by this yellow
7 band here.

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A. The yellow band represents
the diaphragmatic paralysis. That is the phrenic
nerve paralysis that occurred at that time. It was
an associated injury to the phrenic nerve at the time
of the operation about which I have spoken before,
but it had considerable bearing I think on the way
this baby behaves.

3

Q. Thank you, Doctor, very much.

4

Indeed when Baby Dawson was in the
Hospital for the second operation, that had been
earlier in the year in 1980, hadn't it?

5

A. Yes.

6

Q. She had been admitted March
26th and stayed in the Hospital for approximately
six or seven weeks and was discharged on May 13th,
1980?

7

A. Yes.

8

Q. She was readmitted July 23rd.

9

Can you tell us, Doctor, the reason for her readmission
in July?

10

A. She was discharged I believe
back to the hospital in Sudbury.

11

Q. Yes.

12

A. Which I think gives some
indication of the difficulties that they had with this

13

14



EE.2

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2 baby after operation, most of which were not actually
3 connected to the repair problem except in the nature
4 of the diaphragmatic paralysis.

5 I understand, although I don't have
6 personal knowledge of the detail, but I understand
7 that the baby had other admissions - may have been
8 discharged from the hospital in Sudbury and then came
9 back in again. Several times this went on back and
10 forth, I think, prior to the transfer because of
failure to progress, back to the Hospital.

11 Q. Essentially that was the
12 reason for her presenting again at the Hospital for
13 Sick Children on July 23rd, was it not, failure to
14 thrive. She just wasn't getting along very well?

15 A. That is right.

16 Q. She was not growing, gaining
17 weight and so on, and it was a complication as you have
18 said, of the paralysis of the right hemidiaphragm,
aphrenic nerve problem.

19 At the time of her admission I
20 understand she had been and was being treated with
21 digoxin and aldactazide.

22 Doctor, are those drugs which are
23 classically prescribed for congestive heart failure?

24 A. For congestive heart failure,
yes.

25



EE.3

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Q. And that was one of the
problems with this little girl in July, 1980 I take it?

4

5

6

A. She was still on those drugs
and I think there was difficulty in being sure there
wasn't a heart failure element.

7

THE COMMISSIONER: Excuse me, what
was the other drug?

8

9

MR. LAMEK: Aldactazide, Mr.

Commissioner.

10

11

Q. Perhaps you can just make it
clear to us, Doctor, what is aldactazide?

12

13

A. Aldactazide is a diuretic
combination drug.

14

15

16

17

18

19

Q. Page 87 of the chart which is
the medication record, it appears, does it not, that
upon her admission to the Hospital for Sick Children
on July 23rd the administration of digoxin and
aldactazide were continued although she does not
appear from this record at least to have received
doses of those drugs in the evening of the July 27th.

20

21

22

23

24

25

I wonder, Doctor, can you summarize
this baby's course in the Hospital for us from July
the 23rd to the 28th when she died?

A. Well, as I have said before I
am not the physician of record, but I understand that



EE.4

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2 the baby, the problem here was one of growth failure
3 despite the surgical intervention of repair of the
4 defects, and there was a problem with the difficulty
5 breathing which was ascribed to the diaphragmatic
6 paralysis, particularly in relation to the low
7 weight of this baby.

8

9 I think the baby was - I think I saw
10 a weight of 3.8 kilograms, and that is not any
11 different from what it was at the time of the
12 discharge previously, and it is way under what one
13 would expect even for a baby of that particular
14 gestational age.

15

16 So there was real concern that the
17 baby not growing was a high risk infant, and with the
18 respiratory problem there was concern that would
19 predispose this baby to additional stress from
20 infection in the lung, and that one of the
21 considerations should be to whether or not the right
22 diaphragm should be stabilized so that instead of
23 moving in a paradoxical fashion as these diaphragms
24 do under these conditions, it would be put in a mid
25 position, a neutral position, and not waggle around
all the time.

26

27

28

29

Q. And could that be surgically
effected?

A. That can be done surgically.



EE.5

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Q. Was it proposed that that

happen with respect to --

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A. I think this was one of the considerations for the transfer of the baby here, although I think it was a total re-evaluation that they had in mind. So that these were the principal issues that had to be addressed: the nutrition of the baby because shortly there wouldn't be any weight left, as it were, and that had to be addressed, and the question of whether surgical treatment of the paralyzed diaphragm would make a difference to the situation.

Q. Well, certainly throughout the progress notes one gleans the message pretty clearly that she was a rather reluctant feeder?

A. Yes, indeed.

Q. But is there anything in the chart, Doctor, with respect to her course in that period that you regard as important in understanding her death and the circumstances in which that death occurred?

A. I think she had an up and down course, lethargic one day, and so on, so that in itself was a reflection of her poor status.

The only thing that I could see



EE.6

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2 looking through the record was that in the concluding
3 period of her admission she had evidence of early
4 respiratory failure.

5 Q. I am sorry, where in particular
6 can I find references to that in the chart, Doctor?

7 A. I think the page that I am
8 referring to is at page 83.

9 Q. Yes.

10 A. Which I am not sure whether
11 that is in exact sequence of pages there. It doesn't
12 look as though it is. It looks as though that page
13 follows the resuscitation efforts, but I don't believe
14 that could be possible.

15 Q. Well, there is an arrest note
16 on the following page as well, Doctor.

17 A. What I am really looking for
18 there is the page that should precede page 83. It
19 isn't page 82, and it is not 81 and it is not 80.

20 It is a note by a Dr. Reynolds, who
21 was a paediatric house officer, paediatric resident.

22 Q. Does it bear his name, Doctor?

23 A. Yes, it does, and on page 83
24 you can see the name.

25 Q. Oh, yes.

A. But I recall having seen this



EE.7

1

2 particular record before in this particular area,
3 and it was an assessment of the baby at that time,
4 and I don't know exactly what the time was.

5

Q. Possibly page 86, Doctor?

6

The handwriting looks similar.

7

A. I think you are absolutely correct. That must be it. Page 86 must be --

8

Q. Should precede page 83?

9

A. Should precede page 83.

10

I think it was because of the fact that on the 27th of July the baby had been particularly lethargic that the matter must have been drawn to the attention of the resident.

11

Q. Yes.

12

A. By the nurse. And he did a review of the situation.

13

He was not particularly concerned about any question of heart failure. There was no fever.

14

Q. Yes.

15

A. The baby was slightly cyanosed and was breathless.

16

Q. Yes.

17

A. Which probably wasn't hugely different from before.

18

19



EE.8

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Q. Yes.

3

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A. I don't know that he necessarily
on that account would have been more concerned than
the possibility that there was either atelectasis or
heart failure, or at least chest infection, and he
records the possibility of chest infection.

7

8

Q. Lower down on the page,
Doctor, he records a respiration rate of 50.

9

10

A. Yes.

11

12

Q. It had not gone up during the
day, "but does seem more breathless now ..." than
something this morning.

13

14

A. Yes.

Q. Is that the note perhaps you
have seen?

15

16

A. You mean "still tachypneic
60/min"? Are we on page 83?

17

18

Q. I am on what is page 86. In
the lower part of the notes to which you were
referring there is a further reference to breath-
lessness which seems more than this morning.

19

20

A. Yes. I am sorry. Although
the respiratory rate I take it does not increase
during the day --

21

22

Q. Yes.

23

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EE.9

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A. That is a little bit discordant, but at any rate he had some feel that there was something going on here in the chest so he decided to start antibiotics, to start intravenous. I don't recall whether it was started, and to have hourly assessment of this baby.

He also got some blood gases done.

Q. Yes.

A. And I think the blood gas is the significant factor of that examination. I think it was an appropriate decision on the part of the house officer but I think the value of the PCO₂ that is circled there is the carbondioxide level in the blood which was 62, and that is well above the normal range and implies that there is retention of carbon-dioxide and that is usually an implication that the lungs aren't working; not working well anyhow.

So I think that is the only part of the examination - one is a little uncertain of what the diuresis after the lasix might mean. It might be implied that there is some degree of heart failure too, and I think that demonstrates some of the difficulties that did exist with this baby, that the breathlessness was difficult to dissociate perhaps from some effect on the cardiac function - effect



EE.10

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2 from the cardiac function as well as the paralyzed
3 diaphragm.

4

Q. Yes.

5

A. It really wasn't very well
clarified.

6

Q. To what stage was consideration
taken of readmitting this child to the operating room
for correction or repair of the paralyzed diaphragm?

9

A. I am not sure of that. I don't
know the answer to that. I think the person who would
be able to clarify that I think would be Dr. Vera Rose.

12

Q. All right. And the antibiotics
being started on the 27th I take it suggest a
suspicion or perhaps a precaution against the
possibility of infection?

15

A. Yes. I think if there is a
question in a debilitated baby of this sort you
cannot wait for a confirmation. You have to treat
it and then it will perhaps be shown not to be an
essential but one wouldn't want to take a chance.

20

Q. But appropriate action appears
to have been taken on the 27th in light of the
observation then made?

22

A. I think so. The question of
what might have been done further about the respiratory

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EE.11

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situation in terms of ventilation could be raised but I think that would be something we would have to ask the doctors at the time because there was no indication there that I can see that they raised that matter further.

Q. Doctor --

A. I am sorry, I missed a point on the chart.

Q. Yes, which page, Doctor?

A. This is page 84, the top of page 84.

Q. Yes.

A. The question that is asked is:

"How much of this is due to a paralyzed right diaphragm needs surgical/respiratory consults and gases tomorrow",

so I think the resident was thinking about it and must have discussed this with the cardiologist and this must have been a decision that, well, let's see how things were the next morning.



14jul83
FF
DMra

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2 Q. Yes.

3

Doctor, you reviewed the course of

4

the child and it was not all plain sailing, of course.
5 Was there anything in the course that you have looked
6 at that is disclosed in the record over the period
7 from the 23rd to the 27th of July that would lead
8 you to believe that Amber Dawson was at risk of
imminent death?

9

A. No. But I would qualify that.

10

This sort of baby with evidence of
11 respiratory failure developing is a high risk for
deterioration. But I would think it fair to say
12 that, hopefully, that could be managed.

13

Q. Now, page 80 of the chart, doctor,
14 the last note before the arrest note in the middle of
15 the page dated July 27, 1980, it is in the middle of
16 two arrest notes, as a matter of fact, covering the
17 period from 7:00 p.m. until 1:30 in the morning, and
it is a note by Nurse Nelles.

18

Incidentally, when we were referring to
19 the last case and I said I guess we have to ask
20 Nurse Nelles about that, the note, of course, was
21 a note of Mrs. Traynor.

22

A. Yes.

23

Q. This is Nurse Nelles' note cover-

24

25



1

FF2 2 ing the period from 7:00 p.m. on the 27th to 1:30 a.m.
3 in the morning of July 28th:

4 "Chest slightly noisy in the upper
5 lobes. Respirations appear laboured
6 at times, up to 62 at midnight. Apex
7 pulse is 130/106 and regular. Be-
8 haviour continues to be lethargic.

9 Nutrition - Dr. Reynolds notified re
10 baby's poor nutritional status and
11 lethargy. Blood work done and IV
12 started in scalp vein at 22:00."

13 I can't read the next line, I'm afraid.

14 "...post-lasix voids, 235 ccs for a
15 total output of 267 cc."

16 Not a particularly well baby, I take it,
17 doctor, but no substantial change from what we have
18 been reading through the week in the chart there, is
19 it?

20 A. I think this was at the time
21 when Dr. Reynolds did his examination and the blood
22 gases are --

23 Q. Ah, yes, the blood gases in the
24 chart, the note itself is not --

25 A. No.

Q. I'm sorry, you're quite right.



Rowe
dr.ex. (Lamek)

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FF3

2 But then at 1:30 in the morning,

3 Nurse Nelles records:

4 "Apex noted to be dropping..."

5 THE COMMISSIONER: That is at 9:30,
isn't it? Is that 1:30?

6 MR. LAMEK: I believe that to be
7 01:30, Mr. Commissioner.

8 THE COMMISSIONER: It looks to me to
9 be 21:30, but perhaps I am wrong. They haven't
10 changed the date.

11 MR. LAMEK: No, the date isn't
12 changed but you will notice, Mr. Commissioner, the
13 date isn't changed and there is a similar uncompleted
14 zero at the head of the previous note, which goes
15 19:00 to 01:30, I believe.

16 THE COMMISSIONER: Oh, yes.

17 MR. LAMEK: Q. "Apex noted to be
dropping. Rate 79 and falling.

18 Dr. Reynolds notified. Respirations
19 about 50 at the time the apex is
noted and quite laboured. Baby
20 started to gag and showed some seizure
activity. Code 25 called and cardio-
21 pulmonary resuscitation initiated."

22 It then refers to the physician's notes.

23

24

25



FF4

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2 Then there are two notes, I believe,
3 and, doctor, maybe you can help me as to why that
4 should be; perhaps two doctors were present at the
5 resuscitation.

6

7 At the top of that page, under date
8 28.7.80, is a note by Dr. Izakawa, whom we identified
9 this morning, and a brief summary of the patient
10 and the history, of course. At the end of his
11 note, 1:55 a.m.:

12

13 "Extreme bradycardia. Resuscitative
14 measures started without success.

15

16 After 45 minutes stopped."

17

18 And at page 84, there is a further
19 note of the arrest and the resuscitation effort by
20 an Associate Resident, whose name, I confess, I cannot
21 read, but it is dated 28.7.80, at 01:47:

22

23 "Increasing respiratory distress during
24 evening. PCO₂ up 62. Sudden recent
25 deterioration to collapse. Initial
condition, gasping spontaneous respira-
tions. Extreme bradycardia. Bag
ventilation and external cardiac
massage commenced. IV given."

26

27 It lists the drugs that were given, indicating no
28 response to those drug administrations and:

29

30 "50 minutes no return of any electrical

31



Rowe
dr.ex. (Lamek)

FF5

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activity. Resuscitation discontinued
on advice of Dr. Izukawa."

2

Who apparently was there at the time.

3

A. Yes.

4

Q. So, recognizing the significance
that you attach to the blood gases information taken
in the evening of the 27th, what we have objectively,
I suggest again, is at 1:30 in the morning a sudden
drop in the heart rate. We have got some gagging
that is recorded, seizure activity, Code 25 called;
all things followed shortly by extreme bradycardia
and the child cannot be resuscitated and is pronounced
dead.

5

Now, in terms of the onset and course
of the terminal events, doctor, is that not essentially
the same picture that we saw five times yesterday and
once this morning?

6

A. It is similar.

7

Q. The same activity and occurrences
seem to be present and, other than the blood gases
to which you have drawn our attention, I believe, if
you would help me a little bit further with that as
to the significance. Is the picture that seems to
emerge from the chart that of an unwell child who
seemed to be tottering along with no particular

8

9



1
2 FF6 episodes of crisis but not a well child and then
3 suddenly goes into a rapid and apparently irreversible
4 deterioration?

5 A. Yes.

6 Q. Now, to what extent does the
7 blood gas information distinguish this situation from
8 any of the others that we have looked at with a
9 similar course of terminal events?

10 A. It just implies that the respiration-
11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

10 respiratory function of the baby is bad and that would be,
11 I guess, particularly significant with a baby whose
12 respiratory rate has gone up, because when you are
13 breathing faster, you blow off more carbon dioxide.

Q. Yes.

A. So, if it doesn't blow off when
15 you are breathing fast, you are in real trouble. So,
16 I think there is a considerable concern in that this
17 respiratory functioning may have been accounting for
18 some of this deterioration.

Q. Yes.

A. I don't know that we can be
20 sure that was the entire picture.

Q. Dr. Rowe, what in your judgment
22 was the reason for, or the explanation of the sudden
23 and rapid decline in Amber Dawson's case? I'm sorry,



1

FF7 2 why did Amber Dawson die when and in the way that
3 she did?

4 A. I don't think we can be absolutely
5 sure.

6 Q. And that, I take it, is why this
7 is one of the cases that was reported to the Coroner?

8 A. I believe that is so.

9 Q. Could you turn to page 66.

10 Did you participate in the decision
11 to report this case to the Coroner?

12 A. No.

13 Q. Page 66, is that extract from
14 the Coroner's Act that I understand appears on the
15 back of the Coroner's Office form of Post Mortem Report?

16 Do you know under which clause of
17 Section 9(1) this case was reported? Was it reported
18 I would not have thought under (a); it was not thought
19 to be a case of violence, misadventure or negligence?

20 A. No.

21 Q. Or misconduct or malpractice?

22 A. No.

23 Q. It wasn't a matter of pregnancy
24 or unfair means.

25 Do you know whether it was reported
because it was considered to be a death that occurred



Rowe
dr.ex. (Lamek)

FF8 1

2 suddenly and unexpectedly or:

3 " (g) under such circumstances as may
4 require investigation."

5 Why was it considered a Coroner's
6 death?

7 A. I am not absolutely sure. I
8 think we would have to ask the cardiologists involved.
9 I think that Dr. Izukawa and Dr. Olley were the two
10 people involved with that family. I would personally
11 think that there are good medical reasons why the
12 baby might have died. - respiratory difficulty,
13 respiratory failure in a chronically ill baby. I
14 think it is a borderline situation for reporting to
15 the Coroner, but I think that perhaps it was a wise
16 decision to do so.

17 Q. At page 63 of the record, which
18 is part of the Coroner's Act Form of Post Mortem
19 Report, under "Cause of Death", the information is
20 supplied by the pathologist, who is Dr. Cutz of the
21 Hospital For Sick Children, is he not?

22 A. Yes.

23 Q. "The immediate anatomical cause
24 of death not determined."

25 However, he does give:

26 " (contributing factors: congenital



1

2

FF9 heart disease, right hemidiaphragm
3 paralysis)."

4

Even at autopsy, Dr. Cutz could not
5 identify something that he could say with any confi-
dence was the anatomical cause of death; is that
6 correct?

7

A. Yes. I believe he did find some
8 perforation in the stomach.

9

Q. That's true. And Dr. Bain had
10 something to say about that, did he not?

11

A. Yes.

12

THE COMMISSIONER: That is Exhibit...?

13

MR. LAMEK: I'm afraid I'm not very
good at remembering numbers, Mr. Commissioner.

14

Mr. Registrar, the number of Dr. Bain's
15 report?

16

THE REGISTRAR: 48, I think it is.

17

MR. LAMEK: Yes.

18

Q. Dr. Bain said of this baby:

19

"She was placed in this category..."

20

That is the one on which ^{he} you wanted to comment:

21

"...for several reasons. She was

22

almost a year old. She had had open
heart surgery at age nine months.

23

Following this she had a paralyzed

24

25



Rowe
dr.ex. (Lamek)

FF10

1
2 diaphragm and had had several hospital
3 admissions, required digoxin and
4 diuretics to keep her out of heart
5 failure. However, her general condi-
6 tion, although poor, was stable until
7 about the day before her arrest. At
8 this time, her respirations became
9 rapid and laboured.

10 At autopsy, there was softening
11 of the upper end of the stomach with
12 actual perforation, which they felt was
13 precipitated by vomiting. A lung was
14 collapsed.

15 I feel it is virtually certain
16 that the perforation of the stomach
17 was sufficient to trigger her cardiac
18 arrest in her poor condition."

19 Now, doctor, do you agree with Dr. Bain's
20 assessment that the stomach perforation, apparently
21 caused by her, or presumably caused by vomiting, was
22 sufficient to trigger her cardiac arrest?

23 A. That is a possibility.

24 Q. Is it virtually certain?

25 A. I don't think I can say that.

Q. And the difference between you and



Rowe
dr.ex. (Lamek)

1

FF11 2 Dr. Bain then, the difference --

3

A. One of degree.

4

Q. -- is the difference in confidence
level?

5

A. Yes. He is a much more skilled
pediatrician than I ever was. So, I would be pre-
pared to accept his comment.

8

Q. Doctor, that is very gracious
of you. We will have to ask you about his comment.
Your own view would be something less than virtually
certain that that would trigger the arrest?

11

A. Yes.

12

Q. Now, as of January 12, 1981,
Amber Dawson's death was one of the those I recall
that you did find as unexpected, according to your
definition of that term?

16

A. Yes.

17

Q. Was it not?

18

A. Yes.

19

Q. As of January 12, 1981, did you
have any explanation for Amber Dawson having died
when and in the manner that she did?

21

A. I think it was felt that the
cause of death was respiratory in the conclusions and
that this was due to the fact that she was so wasted

24

25



Rowe
dr.ex. (Lamek)

1

FF12 2 and in poor status that what might otherwise, for a
3 baby, have been something that could have been
4 weathered, for this particular infant, weighing what
5 she did at the age she was, that could explain the
6 death.

7 Q. It could explain the death.

8 Fairly, doctor, and as I am understanding
9 you, there is still an air of doubt about the cause
of this baby's death?

10 A. Yes.

11 Q. The direct cause of her death.

12 A. Yes.

13 Q. Doctor, it may not have occurred
14 to you at the time but were Amber Dawson's terminal
15 events and the course of those events consistent with
digoxin intoxication?

16 A. Yes.

17

18 —

19

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Q. Did that occur to you as a
possible explanation of this death?

3

A. No.

5

Q. Has it since occurred to you
as a possible explanation of this death?

6

A. Not since the preliminary
hearings and the circumstances surrounding the...

7

Q. I'm sorry?

9

A. Not since the circumstances
surrounding this whole investigation.

10

Q. I don't understand you.

11

A. Well, because of the considera-
tion given to these babies by all the analyses that
have been done since the whole matter became under
the aegis of the police.

12

Q. Do you say it has not occurred
to you that that is a possible explanation of Amber
Dawson's death or that it has occurred to you, I'm
sorry?

13

A. It has occurred to me.

14

Q. Oh, it has occurred to you.

15

A. Yes.

16

MR. LAMEK: Mr. Commissioner, is
this an appropriate time to adjourn for the day?

17

THE COMMISSIONER: Yes.

18

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MR. LAMEK: Indeed, for the week.

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THE COMMISSIONER: Yes, yes until --
anyone, no problems then?

5

6

7

MR. BOGART: Yes, Mr. Commissioner,
just one question. Do we now have all the medical
records that Mr. Lamek intends to deal with in this
first segment of Dr. Rowe's evidence?

8

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MR. LAMEK: No.

THE COMMISSIONER: The answer to that
is no because I guess that is because they aren't
all done yet, is that right?

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MR. LAMEK: They were not at the
time I left this morning. I am certainly prepared to
do this if I can, Mr. Commissioner. I will call
counsel or have counsel called tomorrow if possible,
if not on Monday morning, to let them know that
additional charts will be available to be picked up
at the Commission's office.

18

19

THE COMMISSIONER: Will we all be
arrested under the Krever rules though?

20

21

MR. LAMEK: I'm sorry?

THE COMMISSIONER: Will we all be
arrested under the Krever rules?

22

23

MR. LAMEK: Oh, that's right, we
should be marking them, shouldn't we.

24

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THE COMMISSIONER: We will all be arrested for distributing these.

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MR. LAMEK: Well, certainly we will not be on to any -- well, we will be on to new ones, I'm sorry. Maybe we will just have to do our best with the new material that is going to come into counsel hands on Tuesday.

8

9

THE COMMISSIONER: We haven't anything available here we could put to the witness. That's a problem you see, we can't really distribute them.

10

11

MR. LAMEK: Yes.

Commissioner

THE WITNESS: But I tell you what is going to happen at any rate. Mr. Lamek has revealed to me that it is touch and go whether he is even going to finish on Tuesday with this witness. So that at least you will have that time frame and more.

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MR. BOGART: That was going to be

my next question, sir. Thank you very much.

THE COMMISSIONER: Well, I think that

that's it, but certainly you will want time to

consider these reports. Yes, Miss Symes?

MS. SYMES: Yes, Mr. Commissioner,

perhaps I could ask Mr. Lamek. We have started now through the list of deaths. Is it your intention to



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put to Dr. Rowe all 46 deaths?

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MR. LAMEK: No, not at this time.

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Mr. Commissioner, what I propose to do with Dr. Rowe at this stage is to lead his evidence as to the reviews of death which he conducted prior to the explosion of public suspicion about the question of digoxin. What I want from Dr. Rowe, if I can have it at this time, is the impressions and judgments that he formed of these deaths before digoxin became a public issue and a matter of public suspicion.

Now, I understand that at a later stage Dr. Rowe reviewed later deaths in some detail and indeed went back and reviewed some of these deaths that he has already talked about.

THE COMMISSIONER: What ones are those, what babies?

MR. LAMEK: I'm sorry.

THE COMMISSIONER: Can you tell us what babies you are going to put to him?

MR. LAMEK: Yes, they are those that are listed on the last page of the minutes of January 12th, subject to the ---

THE COMMISSIONER: So, it is only the babies that died up until January?



1

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MR. LAMEK: Until the end of the year,
really.

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THE COMMISSIONER: Yes.

5

MR. LAMEK: And then I will hope to
have Dr. Rowe back at a later stage to talk about
the reviews that he subsequently did when there was
a rather different atmosphere about.

8

THE COMMISSIONER: So, if that helps
you, Miss Symes.

10

MS. SYMES: Yes.

11

THE COMMISSIONER: The babies up
until January. Yes, Mr. Strathy?

13

MR. STRATHY: I wonder if I could
ask for some further assistance from Mr. Lamek.
There have been several occasions during this
Commission, during the course of the Doctor's
evidence that he has suggested Dr. Freedom should
be approached and we have also now had put in evidence
Dr. Bain's report and he comments on a number of
the deaths. I'm just wondering, is it Mr. Lamek's
intention to call Dr. Freedom and Dr. Bain?

20

MR. LAMEK: It most certainly is.

21

THE COMMISSIONER: Yes.

22

MR. LAMEK: Dr. Freedom I gather is
not going to be available for the balance of this

24

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month but that may be an entirely academic considera-
3
tion anyway.

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Dr. Bain will be available at a
later stage and I do propose to call him to give
evidence as to the matters contained in his report
and the impressions he formed, recognizing that that
was a review that was made after the Preliminary
Inquiry had been completed, at a time when Dr. Bain
did have access, albeit only through the information
at the Preliminary Inquiry, to certain information
relating to digoxin levels.

12

13

Yes, Dr. Bain will be called and it
is my intention to call Dr. Freedom as well.

14

15

MR. SCOTT: Mr. Commissioner, do I
understand then that Mr. Lamek expects to finish his
examination in chief on Tuesday?

16

17

MR. LAMEK: No, the Commissioner has
said perhaps kindly that it is touch and go whether I
will.

19

20

MR. SCOTT: I didn't know whether that
was facetious or realistic.

21

22

THE COMMISSIONER: I hope it is more
go than touch. I would hope that he would finish.

23

24

MR. LAMEK: I will do my best.

THE COMMISSIONER: Yes.

25

